Filing at a Glance

Company: North American Specialty Insurance Company

Product Name: AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing	SERFF Tr Num: ERCB-127970774	State: Arkansas
TOI: H12 Health - Excess/Stop Loss	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H12.004 Self-Funded Health Plan	Co Tr Num: AS-ESLE-AR-11-06350-1-F	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Robin Bromell	Disposition Date: 01/31/2012
	Date Submitted: 01/12/2012	Disposition Status: Approved-Closed
Implementation Date Requested: 03/01/2012		Implementation Date:

State Filing Description:

General Information

Project Name: AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing	Status of Filing in Domicile: Pending
Project Number: NAS-ESLE-AR-11-06350-1-F	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 01/31/2012	
State Status Changed: 01/31/2012	Deemer Date:
Created By: Robin Bromell	Submitted By: Robin Bromell
Corresponding Filing Tracking Number:	

Filing Description:

North American Specialty Insurance Company is filing an enhancement to the Excess Stop Loss Program. This enhanced program provides excess coverage over self-funded employee benefit plans.

The policy provides excess coverage at a specific retention level chosen by the self-insured employer. The coverage is for benefits provided under the Self-Insured Employee Benefit Plan. The maximum coverage is typically $1 million per member per year, less the employer’s specific retention. Aggregate coverage is also available with policy limits of at

least $1 million. This product is available for employers with more than 50 employees. The North American Specialty Insurance Company targets employers with 200+ employees.

The forms being filed are identical to the forms that were recently filed and approved for Westport Insurance Corporation under State Filing Number 49864 with exception of the Company name and NAS added to form number. Several of these forms will replace previously approved forms. We have included side-by-side comparisons of the replaced forms.

The following forms are being withdrawn:
SP 001 217 1100 NAS – Deleted Covered Unit(s) Endorsement
SP 001 225 1100 NAS – Lifetime Limit Endorsement
SP 001 239 1100 NAS – Replacement Policy Endorsement
SP 001 240 1100 NAS – Cancellation Endorsement
SP 001 243 1100 NAS – Delete Covered Units(s) Endorsement
SP 001 244 1100 NAS – Policy Number Endorsement
SP 001 246 1100 NAS – Actively at Work Endorsement
SP 4 550 0509 NAS – Experimental and/or Investigational Definition Endorsement

This filing is being submitted under the Prior Approval provisions. We respectfully request an effective date of March 1, 2012.

Please let me know if you have questions or concerns. Thank you for your consideration of this filing.

Company and Contact

Filing Contact Information

Robin Bromell, Compliance Specialist
5200 Metcalf
Overland Park, KS 66201
robin_bromell@swissre.com
800-255-6931 [Phone] 5503 [Ext]

Filing Company Information

North American Specialty Insurance Company
5200 Metcalf
Overland Park, KS 66201
(800) 255-6931 ext. [Phone]
CoCode: 29874
Group Code: 181
Group Name: Swiss Re
FEIN Number: 02-0311919
State of Domicile: New Hampshire
Company Type:
State ID Number:

Filing Fees

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*		
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

Fee Required?	Yes
Fee Amount:	$1,700.00
Retaliatory?	No
Fee Explanation:	$50 per form filed
	34 forms being filed x $50 = $1700.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
North American Specialty Insurance Company	$1,700.00	01/12/2012	55251962

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*		
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/31/2012	01/31/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	01/13/2012	01/13/2012	Robin Bromell	01/23/2012	01/23/2012

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
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Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

Disposition

Disposition Date: 01/31/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
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Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Forms Memo & Side-By-Side Comparisons	Approved-Closed	Yes
Form	Excess Medical Indemnity Policy	Approved-Closed	Yes
Form	Specific No Laser Rate Cap (NLRC) Endorsement	Approved-Closed	Yes
Form	Add Plan Endorsement	Approved-Closed	Yes
Form	Address Endorsement	Approved-Closed	Yes
Form	Administrator Endorsement	Approved-Closed	Yes
Form	Aggregate Indemnity Limit Endorsement	Approved-Closed	Yes
Form	Aggregate Indemnity Percentage Endorsement	Approved-Closed	Yes
Form	Aggregate Liability Basis Endorsement	Approved-Closed	Yes
Form	Aggregate Monthly Premium Rate Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Retention Option Endorsement	Approved-Closed	Yes
Form	Annual Payment of Premium Endorsement	Approved-Closed	Yes
Form	Attachment Point Endorsement	Approved-Closed	Yes
Form	Covered Unit(s) Specific and Aggregate Excess Endorsement	Approved-Closed	Yes
Form	Covered Unit(s) Specific Excess Endorsement	Approved-Closed	Yes
Form	Delete Plan Endorsement	Approved-Closed	Yes
Form	Insured Endorsement	Approved-Closed	Yes
Form	Aggregate Loss Limit Per Person Endorsement	Approved-Closed	Yes
Form	Monthly Aggregate Reimbursement Endorsement	Approved-Closed	Yes
Form	Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement	Approved-Closed	Yes
Form	Non-Medical Benefits Covered Specific Excess Endorsement	Approved-Closed	Yes
Form	Participant Endorsement	Approved-Closed	Yes

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Form	Plan Name Endorsement	Approved-Closed	Yes
Form	Policy Period Endorsement	Approved-Closed	Yes
Form	Quarterly Payment of Premium Endorsement	Approved-Closed	Yes
Form	Specific Retention Each Person Endorsement	Approved-Closed	Yes
Form	Specific Excess Premium Endorsement	Approved-Closed	Yes
Form	Specific Indemnity Percentage Endorsement	Approved-Closed	Yes
Form	Specific Liability Basis Endorsement	Approved-Closed	Yes
Form	Major Diagnosis Endorsement	Approved-Closed	Yes
Form	Specific Terminal Liability Option Endorsement	Approved-Closed	Yes
Form	Aggregate Terminal Liability Option Endorsement	Approved-Closed	Yes
Form	Medicare Benefits Exclusion Endorsement	Approved-Closed	Yes
Form	Other Carrier Transplant Coverage	Approved-Closed	Yes
Form	Specific Policy Period Limit Endorsement	Approved-Closed	Yes
Form	Delete Covered Unit(s) Endorsement	Approved-Closed	Yes
Form	Lifetime Limit Endorsement	Approved-Closed	Yes
Form	Replacement Policy Endorsement	Approved-Closed	Yes
Form	Cancellation Endorsement	Approved-Closed	Yes
Form	Delete Covered Unit(s) Endorsement	Approved-Closed	Yes
Form	Policy Number Endorsement	Approved-Closed	Yes
Form	Actively at Work Endorsement	Approved-Closed	Yes
Form	Experimental and/or Investigational Definition Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/13/2012
Submitted Date	01/13/2012
Respond By Date	

Dear Robin Bromell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Excess Medical Indemnity Policy, SP 5 117 0911 NAS (Form)

Comment:

With respect to the face page of the policy, please add language that reads: Any policies issued in Arkansas will be governed by the State of Arkansas.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
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TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/23/2012
Submitted Date	01/23/2012

Dear Rosalind Minor,

Comments:
This is in response to your 01/13/2012 Objection Letter in which you had a concern with this filing.

Response 1

Comments: Please note that our face page states as follows: "This Policy is issued in, and will be governed by, the laws of the State of Delivery shown above, unless otherwise preempted by federal law....".

In practice, for an Arkansas risk, the page would reflect the state of Arkansas under "State of Delivery" and thus per the above language, the laws of the state of Arkansas would govern the issued policy.

We respectfully request reconsideration of this form as we would prefer to have this language as is since it applies the same for any state in which the policy is issued.

Also, this same policy form, SP 5 117 0911, was approved for Westport Insurance Corporation under State Filing Number 49864.

Related Objection 1

Applies To:

- Excess Medical Indemnity Policy, SP 5 117 0911 NAS (Form)

Comment:

With respect to the face page of the policy, please add language that reads: Any policies issued in Arkansas will be governed by the State of Arkansas.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
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TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
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Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

No Rate/Rule Schedule items changed.

Please let me know if you have additional questions or concerns. Thank you for your continued consideration of this filing.

Sincerely,
Robin Bromell

Sincerely,
Robin Bromell

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/31/2012	SP 5 117 0911 NAS	Policy/Contract/Fraternal Certificate	Excess Medical Indemnity Policy	Revised	Replaced Form #: SP 001 236 1100 NAS Previous Filing #:	0.000	SP 5 117 0911 NAS .pdf
Approved-Closed 01/31/2012	SP 5 149 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific No Laser Rate Cap (NLRC) Endorsement	Initial		0.000	SP 5 149 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 150 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Add Plan Endorsement	Revised	Replaced Form #: SP 001 210 1100 NAS Previous Filing #:	0.000	SP 5 150 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 151 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Address Endorsement	Revised	Replaced Form #: SP 001 211 1100 NAS Previous Filing #:	0.000	SP 5 151 0911 NAS.pdf

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*		
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*			
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TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*		
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*				
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*				

Approved-Closed 01/31/2012	SP 5 152 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Administrator Endorsement	Revised	Replaced Form #: SP0.000 001 212 1100 NAS Previous Filing #:	SP 5 152 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 153 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Indemnity Limit Endorsement	Revised	Replaced Form #: SP0.000 001 219 1100 NAS Previous Filing #:	SP 5 153 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 154 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Indemnity Percentage Endorsement	Revised	Replaced Form #: SP0.000 001 220 1100 NAS Previous Filing #:	SP 5 154 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 155 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Liability Basis Endorsement	Revised	Replaced Form #: SP0.000 001 223 1100 NAS Previous Filing #:	SP 5 155 0911 NAS.pdf
Approved-Closed	SP 5 156 0911 NAS	Policy/Contract/Fraternal	Aggregate Monthly Premium Rate	Revised	Replaced Form #: SP0.000 001 230 1100 NAS	SP 5 156 0911 NAS.pdf

01/31/2012		al Certificate: Amendment, Insert Page, Endorsement or Rider	Endorsement		Previous Filing #:	
Approved-Closed 01/31/2012	SP 5 157 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregating Specific Retention Option Endorsement	Revised	Replaced Form #: SP0.000 001 214 1100 NAS Previous Filing #:	SP 5 157 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 158 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Annual Payment of Premium Endorsement	Revised	Replaced Form #: SP0.000 001 238 1100 NAS Previous Filing #:	SP 5 158 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 159 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Attachment Point Endorsement	Revised	Replaced Form #: SP0.000 001 215 1100 NAS Previous Filing #:	SP 5 159 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 160 0911 NAS	Policy/Contract/Fraternal Certificate:	Covered Unit(s) Specific and Aggregate Excess Endorsement	Revised	Replaced Form #: SP0.000 001 216 1100 NAS Previous Filing #:	SP 5 160 0911 NAS.pdf

SERFF Tracking Number:	*ERCB-127970774*		*State:*	*Arkansas*		
Filing Company:	*North American Specialty Insurance Company*		*State Tracking Number:*			
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*					
TOI:	*H12 Health - Excess/Stop Loss*		*Sub-TOI:*	*H12.004 Self-Funded Health Plan*		
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*					
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*					
		Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/31/2012	SP 5 161 0911 NAS	Policy/Contract/Fraternal Certificate	Covered Unit(s) Specific Excess Endorsement	Revised	Replaced Form #: SP0.000 001 242 1100 NAS Previous Filing #:	SP 5 161 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 162 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Delete Plan Endorsement	Revised	Replaced Form #: SP0.000 001 218 1100 NAS Previous Filing #:	SP 5 162 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 163 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Insured Endorsement	Revised	Replaced Form #: SP0.000 001 222 1100 NAS Previous Filing #:	SP 5 163 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 164 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Loss Limit Per Person Endorsement	Revised	Replaced Form #: SP0.000 001 226 1100 NAS Previous Filing #:	SP 5 164 0911 NAS.pdf
Approved-Closed	SP 5 165 0911 NAS	Policy/Contract/Fratern	Monthly Aggregate Reimbursement	Revised	Replaced Form #: SP0.000 001 213 1100 NAS	SP 5 165 0911 NAS.pdf

SERFF Tracking Number:	*ERCB-127970774*		*State:*	*Arkansas*	
Filing Company:	*North American Specialty Insurance Company*		*State Tracking Number:*		
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01/31/2012	al Certificate: Amendment, Insert Page, Endorsement or Rider	Endorsement		Previous Filing #:	
Approved-Closed 01/31/2012	SP 5 167 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement	Revised	Replaced Form #: SP0.000 001 227 1100 NAS Previous Filing #:	SP 5 167 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 168 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Non-Medical Benefits Covered Specific Excess Endorsement	Revised	Replaced Form #: SP0.000 001 241 1100 NAS Previous Filing #:	SP 5 168 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 169 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Participant Endorsement	Revised	Replaced Form #: SP0.000 001 248 1100 NAS Previous Filing #:	SP 5 169 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 170 0911 NAS	Policy/Contract/Fraternal Certificate:	Plan Name Endorsement	Revised	Replaced Form #: SP0.000 001 228 1100 NAS Previous Filing #:	SP 5 170 0911 NAS.pdf

		Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/31/2012	SP 5 172 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Period Endorsement	Revised	Replaced Form #: SP0.000 001 229 1100 NAS Previous Filing #:	SP 5 172 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 173 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Quarterly Payment of Premium Endorsement	Revised	Replaced Form #: SP0.000 001 237 1100 NAS Previous Filing #:	SP 5 173 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 174 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Retention Each Person Endorsement	Revised	Replaced Form #: SP0.000 001 232 1100 NAS Previous Filing #:	SP 5 174 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 175 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert	Specific Excess Premium Endorsement	Revised	Replaced Form #: SP0.000 001 231 1100 NAS Previous Filing #:	SP 5 175 0911 NAS.pdf

		Page, Endorsement or Rider				
Approved-Closed 01/31/2012	SP 5 176 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Indemnity Percentage Endorsement	Revised	Replaced Form #: SP0.000 001 221 1100 NAS Previous Filing #:	SP 5 176 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 177 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Liability Basis Endorsement	Revised	Replaced Form #: SP0.000 001 224 1100 NAS Previous Filing #:	SP 5 177 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 337 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Major Diagnosis Endorsement	Revised	Replaced Form #: SP0.000 001 247 1100 NAS Previous Filing #:	SP 5 337 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 338 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Specific Terminal Liability Option Endorsement	Revised	Replaced Form #: SP0.000 001 234 1100 NAS Previous Filing #:	SP 5 338 0911 NAS.pdf

		nt or Rider					
Approved-Closed 01/31/2012	SP 5 340 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Terminal Liability Option Endorsement	Revised	Replaced Form #: SP001 233 1100 NAS Previous Filing #:	0.000	SP 5 340 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 342 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Medicare Benefits Exclusion Endorsement	Initial		0.000	SP 5 342 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 343 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Other Carrier Transplant Coverage	Initial		0.000	SP 5 343 0911 NAS.pdf
Approved-Closed 01/31/2012	SP 5 344 0911 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Policy Period Limit Endorsement	Initial		0.000	SP 5 344 0911 NAS.pdf
Approved-	SP 001 217	Policy/Cont	Delete Covered	Other	Other Explanation:	0.000	

Closed 01/31/2012	1100 NAS	ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Unit(s) Endorsement		Being Withdrawn	
Approved-Closed 01/31/2012	SP 001 225 1100 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Lifetime Limit Endorsement	Other	Other Explanation: Being Withdrawn	0.000
Approved-Closed 01/31/2012	SP 001 239 1100 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Replacement Policy Endorsement	Other	Other Explanation: Being Withdrawn	0.000
Approved-Closed 01/31/2012	SP 001 240 1100 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Cancellation Endorsement	Other	Other Explanation: Being Withdrawn	0.000
Approved-Closed 01/31/2012	SP 001 243 1100 NAS	Policy/Contract/Fraternal	Delete Covered Unit(s) Endorsement	Other	Other Explanation: Being Withdrawn	0.000

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*		
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Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*				

		Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 01/31/2012	SP 001 244 1100 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Number Endorsement	Other	Other Explanation: Being Withdrawn	0.000
Approved-Closed 01/31/2012	SP 001 246 1100 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Actively at Work Endorsement	Other	Other Explanation: Being Withdrawn	0.000
Approved-Closed 01/31/2012	SP 4 550 0509 NAS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Experimental and/or Investigational Definition Endorsement	Other	Other Explanation: Being Withdrawn	0.000

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

A Stock Insurance Company
650 Elm Street, 6th Floor ▪ Manchester, NH 03101-2524
(800) 542-9200

EXCESS MEDICAL INDEMNITY POLICY

Insured:

Policy Number:

Effective Date:

State of Delivery:

This **Policy** is a legal contract. In consideration of premium **Paid**, North American Specialty Insurance Company agrees to reimburse **Losses** in accordance with the terms of this **Policy**. Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine your rights, duties and what is and is not covered.

Throughout this **Policy** and the **Schedule**, the words "you" and "your" refer to the Insured shown above. The words "we," "us" and "our" refer to North American Specialty Insurance Company. Other words and phrases that appear in bold letters have defined meaning. Refer to the **Policy** and **Schedule** if you have questions on the meaning of these terms.

This **Policy** is issued in, and will be governed by, the laws of the State of Delivery shown above, unless otherwise preempted by federal law. Acceptance of this **Policy** means that the Insured agrees to the terms and conditions of this **Policy**.

This **Policy** is executed by printing the facsimile signatures of our President and Secretary on the attached signature page and by the actual signature of the authorized representative on the **Schedule**.

THE ATTACHED DISCLOSURES, COVERAGE FORM(S) AND OTHER FORMS AND ENDORSEMENTS, IF ANY, FORM THE ATTACHED POLICY.

IN WITNESS WHEREOF, North American Specialty Insurance Company has caused this **Policy** to be executed and attested by our duly authorized representative(s).

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted	*Facsimile signature to be inserted*
President	Secretary

TABLE OF CONTENTS

SCHEDULE OF INSURANCE

THIS IS A CLAIMS PAID POLICY
PLEASE READ CAREFULLY

The following insurance only applies to the **Policy Period** shown in this **Schedule**. A separate **Schedule** will be issued for each succeeding **Policy Period**.

1. **INSURED:**

2. **ADDRESS:**

3. **POLICY NUMBER:**

4. **POLICY PERIOD:**

5. **PLAN NAME:**

6. **SPECIFIC EXCESS:**

   a. Liability Basis:

      (1) Claims Incurred from: _____ through _____

      (2) Claims Paid from: _____ through _____

   b. Retention each Person:

   c. Indemnity Percentage:

   d. Policy Period Limit:

   e. Covered Unit(s):

   f. Non-medical Benefits covered:

   g. Premium:

Rating Classification	**Monthly Rate**

7. **AGGREGATE EXCESS:**

This **Policy** ☐ ***includes*** ☐ ***excludes*** Aggregate Excess Coverage. (If neither or both boxes are marked, then th**e** assumption is that Aggregate Excess Coverage is excluded under this **Policy**.)

a. Liability Basis:

(1) Claims Incurred from: _____ through _____

(2) Claims Paid from: _____ through _____

b. Loss Limit Per Person:

c. Attachment Point:

(1) Estimated Attachment Point:

(2) Factor:

(3) Minimum Attachment Point:

d. Indemnity Percentage:

e. Indemnity Limit:

f. Covered Unit(s):

g. Non-medical Benefits covered:

h. Monthly Premium Rate:

8. **ADMINISTRATOR:**

9. **ENROLLMENT:** Total Covered Employees:

10. **MINIMUM NUMBER OF COVERED LIVES:**

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Authorized North American Specialty Representative

Date

SECTION ONE: DEFINITIONS

1. **ADMINISTRATOR** means the organization contracted by you to adjudicate all claims arising from the **Plan**. The act of adjudication shall include but not be limited to the investigation, payment, denial and settlement of claims for **Benefits** under the **Plan**. The **Administrator** is designated in Schedule Item 8.

2. **ALTERNATIVE CARE** means a **Treatment**, identified through a case management provider, which substitutes a covered expense under your **Plan** for another covered expense under your **Plan**. Guidelines regarding the eligible expenses of **Alternative Care Treatment** under this **Policy** are set forth within Section Seven: Claims, Item 6.

3. **BENEFITS** means any medical coverage(s) provided by the **Plan**, and any non-medical coverage(s), provided by the **Plan**, specifically listed in Schedule Items 6(f) or 7(g). Dental, vision, hearing, prescription drugs, prescription drug card, retail prescription drugs, and weekly income **Benefits** are examples of non-medical coverages. Non-medical coverages not listed in the **Schedule** are not covered by this **Policy**.

4. **CASE MANAGEMENT FEES** are fees **Paid** to an independent third party case management provider for the coordination and management of health care delivery to a **Person** covered under the **Plan** through appropriate referrals to qualified and approved medical providers.

5. **COVERED UNIT** means a particular class of **Employees** (and the eligible covered dependents of the **Employees** under the **Plan**) who are covered under the **Plan** and indemnified by this **Policy** and identified under Schedule Items 6(e) or 7(f). A **Covered Unit** may be identified by company name, division, location or group.

6. **EMPLOYEE** means any individual who is employed by you in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired **Employees** or the dependents of retired **Employees** unless specifically identified for coverage under this **Policy** as listed in Schedule Items 6(e) and/or 7 (f).

7. **ENDORSEMENT** means a written alteration or amendment to the terms of this **Policy** issued by us and which is made a part of this **Policy**.

8. **EXPERIMENTAL AND/OR INVESTIGATIONAL** means a **Treatment** which does not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the United States of America medical community or the U.S. federal government oversight agencies at the time services were rendered.

9. **INCURRED** means the date on which services for covered **Benefits** for a covered **Person** are performed by a qualified medical provider.

10. **INDEPENDENT MEDICAL REVIEW** means the analysis of the **Treatment** by a clinical reviewer of a URAC (formerly known as the Utilization Review Accreditation Commission) accredited independent review organization, who is a board certified physician in the same medical specialty or subspecialty of the underlying **Loss**, and both external and independent to the **Plan** and the **Administrator**.

11. **LOSS** or **LOSSES** means the amount **Paid** for claims by you or the **Administrator** for **Benefits** under the **Plan**. **Loss** includes the amount **Paid** by you or the **Administrator** in settlement of claims or in satisfaction of judgments for **Benefits** under the **Plan**. **Loss** also includes **Case Management Fees Paid** by you or the **Administrator** when claims exceed the Retention amount shown in Schedule Item 6(b).

12. **MATERIAL** or **MATERIAL CHANGE** means a change or combination of changes in the risk assumed by us, as solely determined by us. **Material** or **Material Change** includes but is not limited to the following:

    a. a change, modification, or revision to the **Plan** that we determine would increase our risk under this **Policy**;

b. a change or increase in liability due to the acquisition of, merger with, or sale of the Insured to another company or employer;

c. a change in your management, **Administrator's** management, or PPO contracts; or

d. a change in the majority ownership of the Insured.

13. **MEDICALLY NECESSARY** means a **Treatment** that is prescribed by a physician or licensed medical practitioner, who is acting within the scope of his or her license, and meets all of the following elements:

a. Is appropriate for the diagnosis and **Treatment** of an illness, injury, or pregnancy in accordance with generally accepted medical practice and professional standards;

b. Is the most appropriate treatment, supply, device, or level of service to provide safe and adequate care; and

c. Is not **Experimental and/or Investigational**, Cosmetic, Custodial in Nature, or Unproven.

Cosmetic means a **Treatment** or portion of a **Treatment** with the purpose of improving appearance rather than curative or restoration of general health. Noted exceptions to this definition are repairs of congenital cleft palates and breast reconstruction after mastectomy.

Custodial in Nature is care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care. Activities of daily living are defined as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.

Unproven is the lack of scientific evidence or outcome studies to demonstrate the medical effectiveness of the proposed medical **Treatment**.

14. **PAID** means that a claim has been adjudicated by the **Administrator** and funds have actually been disbursed by the **Plan** or **Administrator** as unconditional and direct payment to the applicable **Person** or health care provider(s) during the **Claims Paid** period as defined in Schedule Item 6(a)(2) and/or Schedule Item 7(a)(2), if applicable.

Payment will be deemed made on the date that both:

a. the **Plan** or **Administrator** directly tenders payment by mailing, transmitting or other delivery of a draft, check or wire transfer; and

b. the account upon which the payment is drawn contains and continues to contain sufficient funds to permit the draft, check or wire transfer to be honored by the financial institution upon which it is drawn.

15. **PERSON** means any **Employee** included in a **Covered Unit**, and the eligible covered dependents of the **Employee**, who are enrolled and covered for **Benefits** under the **Plan**.

16. **PLAN** means the self-insured employee benefit plan named in Schedule Item 5 and recorded within a **Plan Document**. You agree to furnish us a copy of the **Plan Document** within ninety (90) days after the beginning of the **Policy Period**. A copy of the **Plan Document** is attached and made a part of this **Policy** as Exhibit A.

17. **PLAN CHANGE** means any alteration or amendment to the **Plan**, but unless each change is sent to us and accepted in writing by us, this **Policy** will apply as if the change had not been made. You agree to furnish a copy of any **Plan Change** to us at least thirty (30) days before it becomes effective.

18. **PLAN DOCUMENT** means the complete written **Plan** and/or trust which govern the operation and administration of the **Plan**, including eligibility, coverage, claim procedures and payment of **Benefits**. The **Plan Document** is not the descriptive booklet given to covered **Persons**, or the summary plan description. The **Plan Document** includes all written instruments governing the **Plan** including any amendments(s) accepted by us pursuant to this **Policy**.

19. **POLICY** means this Excess Medical Indemnity Policy, and the **Schedule,** Exhibits, and **Endorsements** (if any). The **Policy** is a contract of insurance between you (the Insured shown in Schedule Item 1) and us (the Insurer named on the face page of this **Policy**). The terms and conditions of this **Policy** may not be altered or waived except by **Endorsement** issued by us.

20. **POLICY PERIOD** means the period of time shown in Schedule Item 4 and any succeeding **Schedules**.

21. **PROOF OF LOSS** means the documentation of claims **Incurred** under the **Plan** and submitted for reimbursement under this **Policy**. Documentation must be to our satisfaction. The standards of Proof of Loss for each type of claim are further set forth in Section Seven: Claims, Item 11.

22. **SCHEDULE** means the pages of this **Policy** which show your name, the name of the **Plan** and other terms of insurance included in the Schedule of Insurance. A separate **Schedule** will be issued for each succeeding **Policy Period**.

23. **TREATMENT** means any medical procedure, service, device, supply, drug, care or treatment provided to a **Person** by a physician or medical provider.

24. **USUAL, REASONABLE AND CUSTOMARY** means the standard charges assessed by a group, entity, or individual for physician or medical provider services, hospital supplies, hospital bed rates, drugs, ancillary services, or durable medical equipment, to the extent that such charges do not exceed the general level of charges made by other physicians or medical providers who render similar **Treatments** to similarly ill or injured persons in the same geographical area.

SECTION TWO: PREMIUM

1. **CALCULATION**. Each month's premium due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the first day of each month during the **Policy Period**.

2. **DUE DATE**. Premium is due to us on the first day of each month during the **Policy Period**. Each premium payment must be accompanied by a report showing the number of **Employees,** as of the first day of the month, who are part of each Rating Classification shown in Schedule Items 6(g) and 7(h).

3. **GRACE PERIOD**. A Grace Period of thirty-one (31) days following the premium due date will be granted for the payment of each month's premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period.

4. **NON-PAYMENT**. Failure to pay in full any month's premium within the Grace Period will cancel the **Policy** as of the premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full monthly premium is not paid prior to the expiration of the Grace Period.

5. **REINSTATEMENT**. If any premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate the **Policy** on the terms and conditions that we elect at that time.

6. **ADJUSTMENTS**. If you pay any premium in excess of the amounts due to us, you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next premium payment due to us. A request for refund or a claim of offset for a future premium payment must be given to us in writing, stating the basis and calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the premium payment amount was adjusted. No premium adjustments will be allowed after ninety (90) days following the conclusion of the **Policy Period**.

7. **MINIMUM MONTHLY PREMIUM PAYMENTS**. Monthly payments of premium due under this **Policy** will not be less than the minimum monthly premium payment. The minimum monthly premium payment is calculated by multiplying the Minimum Number of Covered Lives, as defined in Schedule Item 10, by the per **Person** premium rates for Specific Excess coverage, as defined in Schedule Item 6(g) and if applicable, for Aggregate Excess coverage, Schedule Item 7(h).

SECTION THREE: SPECIFIC EXCESS

1. **RETENTION EACH PERSON**. You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** shown in Schedule Item 6(b) which is **Incurred** during the dates shown in Schedule Item 6(a)(1) and **Paid** by you or the **Administrator** for **Benefits** under the **Plan** for each **Person** during the dates shown in Schedule Item 6(a)(2).

2. **INDEMNITY**. We will indemnify and reimburse you the percentage shown in Schedule Item 6(c) of the amount of **Loss Paid** by you or the **Administrator** during the **Policy Period** that exceeds the Retention. We will not reimburse you more frequently than one (1) time each month for each **Person** under this **Policy**.

3. **POLICY PERIOD LIMIT**. The amount shown in Schedule Item 6(d) is the limit of the **Loss** for which we will reimburse you with respect to each **Person** during the **Policy Period**. The Policy Period Limit includes the amount of Retention Each Person for each **Policy Period**.

SECTION FOUR: AGGREGATE EXCESS

1. **ATTACHMENT POINT**. You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** equal to the Attachment Point, as defined in Schedule Item 7(c), which is **Incurred** during the dates shown in Schedule Item 7(a)(1) and **Paid** by you or the **Administrator** during the dates shown in Schedule Item 7(a)(2).

   The Attachment Point is calculated for each **Policy Period** as follows: the sum of the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month during the **Policy Period** multiplied by the Attachment Point Factor shown in Schedule Item 7(c)(2). The calculated Attachment Point will not be less than the Minimum Attachment Point amount shown in Schedule Item 7(c)(3).

   The Estimated Attachment Point, as stated in Schedule Item 7(c)(1), is a calculation based upon the total number of covered **Employees** at the beginning of the **Policy Period**, as stated in Schedule Item 9, multiplied by the total number of months within the **Policy Period**, times the Attachment Point Factor, as stated in Schedule Item 7(c)(2). The Estimated Attachment Point is only a reference point for the anticipated aggregate excess retention amount upon binding of this **Policy**. However, for purposes of determining the actual Aggregate Excess retention amount, the above stated Attachment Point calculation will be utilized.

2. **INDEMNITY**. We will reimburse you an amount equal to the Indemnity Percentage as shown in Schedule Item 7(d) multiplied by the difference between the total **Loss** minus the calculated Attachment Point. In calculating the total **Loss** for the applicable **Policy Period**, we will utilize a **Loss Limit Per Person** amount.

3. **LOSS LIMIT PER PERSON**. When calculating our Aggregate Excess indemnity obligation to you, **Loss(es)** pertaining to each **Person** during each **Policy Period** will be limited to the amount shown in Schedule Item 7(b).

4. **AGGREGATE EXCESS INDEMNITY LIMIT**. Our Aggregate Excess Indemnity for each **Policy Period** will not exceed the Indemnity Limit shown in Schedule Item 7(e).

5. **CANCELLATION**. If you cancel this **Policy** before the **Policy Period** expires, no amounts will be reimbursed by us for Aggregate Excess **Losses** under this **Policy**.

SECTION FIVE: AMENDMENTS

1. **WE HAVE THE RIGHT TO AMEND ANY SCHEDULE ITEMS ON THE DATE THAT**:

   a. we accept a **Material Plan Change**;

   b. a **Covered Unit** is added or deleted;

   c. the **Policy Period** expires;

   d. you request a change in **Policy** terms;

   e. a state or federal law **materially** alters your obligation under the **Plan**;

   f. the total number of **Employees** in all **Covered Units** increases or decreases by more than:

      i. Fifteen Percent (15%) during any single month of the **Policy Period**; or

      ii. Twenty-Five Percent (25%) for any three (3) consecutive months of the **Policy Period** combined;

   g. the total number of **Employees** in all **Covered Units** as reported for the first day of the **Policy Period** is fifteen percent (15%) higher or lower than the total number of **Employees** represented by you at binding of coverage of this **Policy** and documented as the Total Covered Employees within Schedule Item 9;

   h. the average monthly claims **Paid** by you or the **Administrator** during the last two (2) months of the previous **Policy Period** exceeds by more than ten percent (10%) the average monthly claims **Paid** during all other months of the previous **Policy Period**;

   i. a **Material Change** in the makeup of the **Employees** of the Insured due to merger or acquisition, unless we have agreed in writing to such change;

   j. you or the **Administrator** provided us with incomplete or inaccurate census and/or claim information, inaccurate **Employee** or dependent qualification or classification, or any other mistake or misrepresentation, with respect to any **Material** term of this **Policy**; or

   k. you or the **Administrator** change PPO networks.

SECTION SIX: EXCLUSIONS

1. **THIS POLICY DOES NOT APPLY:**

   a. to **Loss Paid** by you or the **Administrator** and reported to us more than one (1) year after the end of the **Policy Period** in which the **Loss** is **Paid**;

   b. to expenses, payments or expenditures for any non-medical expenses incurred as a result of the administration of the **Plan**, including but not limited to the following:

i. claims administration, investigation fees, attorneys fees, court cost, and fees for obtaining medical records billed by the **Administrator** (including fees generated from companies owned in whole or in part by the **Administrator,** companies with a corporate or other legal affiliation or joint ownership with the **Administrator**, or by a spouse, child or immediate family member of the **Administrator**, unless we grant prior written authorization. Failure to provide prior disclosure of such an ownership or relationship interest will exclude all indemnifiable **Loss** under this **Policy** attributed to such fees);

ii. compensation paid to officers, employees, consultants, brokers, actuaries, accountants, independent contractors, or any other person or entity performing non-claim services for the **Plan**; and

iii. any surcharges, assessments, or taxes imposed by any federal, state or local government entity, hospital or agency upon self-insurers;

c. to any **Material Plan Change** which we have not accepted in writing;

d. to **Benefits Paid** by you in one **Policy Period** but allocated to another **Policy Period**. No reimbursement will be made under both the Aggregate and Specific Excess provisions of this **Policy** if, by so doing, we would in any way make reimbursement more than once for any **Loss**;

e. to administrative fees related to a prescription drug card program, unless otherwise agreed to by us in writing;

f. to **Experimental and/or Investigational Treatments**;

g. to any **Treatment** that is not **Medically Necessary**;

h. to the cost resulting from a **Loss** that is in excess of the **Usual, Reasonable and Customary** charges;

i. to non-skilled custodial or residential services. Services are deemed to be non-skilled custodial or residential services if the services i) do not require the skill of a licensed Registered Nurse, ii) are not curative and/or restorative in nature, and iii) are primarily intended to assist in the activities of daily living as defined by Medicare (e.g. bathing, dressing, feeding, toileting, transferring);

j. to expenses for **Benefits** for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, and for which the **Person** would be entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, regulation or policy, whether or not such policy is actually in force;

k. to expenses incurred while a **Person** is engaged in an act that is illegal under federal or state law, or as a result of their illegal act. Illegal acts include but are not limited to participation in a riot or other act of civil disobedience; operation of a motorized vehicle (including but not limited to automobile, motorcycle, ATV, boat, personal watercraft and snowmobiles) while intoxicated, as defined by the applicable state law, due to drugs, alcohol, or narcotics; voluntary consumption or use of a controlled substance that has not been legally prescribed by a treating medical provider; or any other charged felony or misdemeanor;

l to expenses incurred resulting from a war, declared or undeclared, hostilities, invasions, insurrections, or civil war;

m. to expenses incurred by a **Person** resulting from a hazardous hobby or activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm or injury. Examples of hazardous hobbies or activities shall include, but not be limited to: skydiving; racing of an automobile, ATV, boat, personal watercraft or motorcycle; hang gliding; and bungee jumping;

n. to expenses incurred by a **Person** while detained or incarcerated in a federal, state, or local jail, penitentiary, correctional facility or correctional hospital;

o. to expenses incurred by a **Person** for cosmetic purposes, unless:

   i. performed to correct functional disorders or congenital anomalies; or

   ii. performed for breast reconstruction of the affected tissue incident to a mastectomy (Women's Health and Cancer Rights Act of 1998); or

   iii. due to accidental injury occurring while the individual is a covered **Person**;

p. to Medicare benefits, presuming that, when applying this exclusion, each **Person** eligible for coverage under Medicare became covered for any parts of Medicare on the earliest possible date entitled, and thereafter continuously maintained the Medicare coverage in force. If it is determined that **Benefits** were provided to a **Person** who was eligible for coverage under Medicare but he or she either i) failed to apply for such Medicare coverage or ii) failed to maintain Medicare coverage in force, then said **Benefits** will also be excluded;

q. for any portion of an expense which you are not obligated to pay under the terms of the **Plan**, or which is reimbursable to you under:

   i. another group health benefit plan; or

   ii. a government or privately supported medical research program; or

   iii. any coordination of benefits or non-duplication of benefit provisions of your **Plan**; or

   iv. any other source;

r. to any billing errors, duplicate bills or duplicate bill items;

s. any amount **Paid** by you or the **Administrator** in excess of a negotiated provider discount, or any penalty or late charge incurred, or discount lost, unless said excess amount, penalty, or late charge has been previously approved by us in writing;

t. to expenses for **Treatment** authorized or approved under any provision of the **Plan** which:

   i. allows the **Administrator** to approve an **Alternative Care Treatment** without prior approval from us; or

   ii. allows the **Administrator** to alter, modify, or waive a **Plan** provision, standard, or limitation; or

   iii. grants you or the **Administrator** discretion to approve coverage for a **Treatment** not otherwise covered under the **Plan**.

   However, if the **Treatment** satisfies the requirements set forth within Section Seven: Claims, Item 5, then such expenses will not be deemed excluded.

u. to expenses for **Treatment** rendered to a **Person** by a family member or relative of the **Person**;

v. to payment of medical expenses in excess of **Plan** limits or terms;

w. to payment of medical expense not covered under the terms of the **Plan**. **Administrator's** use of discretionary authority under the **Plan** does not obligate us to recognize and/or reimburse you under this **Policy** for benefits excluded, limited or not listed within the terms of the current **Plan**; and

x. to any of the following legal obligations:

i. any liability arising out of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or out of any similar federal or state law or regulation;

ii. any payment for litigation cost and expenses, extra-contractual damages, compensatory damages, punitive or exemplary damages or liabilities, including but not limited to those resulting from negligence, intentional wrong doings, fraud, bad faith or strict liability on the part of the **Insured**, **Plan**, **Administrator** or any agent or representative of the **Insured**, **Plan**, or **Administrator**; or

iii. any other fines or penalties imposed upon the **Insured**, **Plan** or **Administrator** by law or regulation, not already addressed herein.

SECTION SEVEN: CLAIMS

1. **ELIGIBLE EXPENSES**. Eligible expenses for a claim against this **Policy** comprise of amounts **Paid** by you for **Medically Necessary Treatments Incurred** by a covered **Person** which:

a. Have been **Paid** in accordance with the terms and conditions of your **Plan**; and

b. Were **Incurred** and **Paid** during the Liability Basis shown in Schedule Item 6(a) or 7(a); and

c. Are **Paid** under a **Benefit** covered by this **Policy**; and

d. Are not otherwise excluded under this **Policy** (Section Six: Exclusions).

2. **YOUR ADMINISTRATOR**.

a. **Administrator** is your contractual agent and does not represent us in any way.

b. You are solely responsible for all fees charged by the **Administrator** for its services rendered to you.

c. **Administrator** may be authorized by you to satisfy the obligations and duties assigned to you under this **Policy**; however the **Administrator's** failure to act or its error in acting will not excuse you from your obligations and duties arising under this **Policy**.

d. **Administrator** will hire counsel to defend all litigation arising out of a denied claim. We reserve the right to participate and control in the defense of any claim which may result in a **Loss** to us.

e. You will provide the **Administrator** with sufficient funds to pay all claims for **Benefits** under the **Plan** as they become due.

f. **Administrator** will pursue and take advantage of all discounts and other cost reducing procedures prior to paying a claim for **Benefits** under the **Plan**. We will not be held accountable for any lost discounts. If **Administrator** is unable to obtain any discount, or only able to obtain a nominal discount (ten percent (10%) or less), or unable to implement managed care opportunities with respect to any **Loss** under the **Plan**, you will notify us immediately. We reserve the right to independently investigate, negotiate and/or pursue any discounts or cost mitigation services available on all **Losses** under the **Plan**. **Administrator** will recognize and honor any discounts or other managed care opportunities identified by us.

g. If you plan to terminate or replace your **Administrator** during the **Policy Period**, you must notify us immediately.

3. **CASE MANAGEMENT PROVIDERS AND EXPENSES**.

a. The case management provider must be either:

i. Approved by us in writing, or

ii. Have current and on-going accreditation by one of the following national organizations: URAC (formerly known as the Utilization Review Accreditation Commission), Commission for Case Manager Certification or the Case Management Society of America.

b. Case management services provided by an employee or affiliated company of the **Administrator** are not eligible for indemnification under this **Policy** unless we give prior written approval.

c. If you or the **Administrator** do not utilize a case management provider, we reserve the right to retain and utilize the services of a case management provider at our own cost and expense.

d. **Case Management Fees** do not include fees **Paid** on a capitated basis (e.g. per **Employee** per month) by you or the **Administrator**.

e. **Case Management Fees** are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.

4. **COST CONTAINMENT FEES**. Fees or charges **Incurred** and **Paid** by you or the **Administrator** for the direct purpose of cost containment for the **Plan** are eligible as a **Loss** under this **Policy** if prior written approval for such fees or charges have been obtained from us. Examples of cost containment fees or charges include but are not limited to the following: negotiation fees, medical cost repricing fees, provider bill audits, network access fees, etc. Cost Containment Fees are subject to the following additional terms:

a. Our acceptance of a cost containment fee or charge will be subject to a demonstration that the work that generated the fees or charges resulted in a cost savings to the **Plan**.

b. Cost containment fees are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.

c. Eligible cost containment fees or charges are only reimbursed for claims in which the total **Loss** exceeds the Retention amount shown in Schedule Item 6(b).

5. **COVERAGE GUIDELINES FOR EXPERIMENTAL AND/OR INVESTIGATIONAL, MEDICALLY NECESSARY, AND USUAL, REASONABLE AND CUSTOMARY MEDICAL TREATMENTS AND EXPENSES**.

a. The **Administrator** will be guided by the following standards in making its determination of whether a **Treatment** is **Experimental and/or Investigational**:

i. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time of the drug or device is furnished; or

ii. If "Documented Medical Evidence" shows that the **Treatment** is the subject of on-going Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis; or

iii. If "Documented Medical Evidence" shows that the prevailing opinion among experts regarding the **Treatment** is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis.

"Documented Medical Evidence" shall mean published reports and articles within authoritative medical and scientific literature, or other publication, written or electronic, by a nationally recognized medical specialty group, in regard to a protocol or **Treatment**.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the U.S. Food and Drug Administration for general use.

Treatment for a specific form of cancer that has not completed U.S. Food and Drug Administration Phase III clinical trials, but is considered to be the current standard of care, may be referred to us for review and determination of exemption from a classification of **Experimental and/or Investigational**.

b. The circumstances under which a physician or licensed medical practitioner has prescribed, ordered, recommended or approved any **Treatment** are not conclusive as to whether such **Treatment** is **Medically Necessary** within the scope of this **Policy**.

c. The **Administrator** will make all initial determinations of **Experimental and/or Investigational** and **Medically Necessary** under the **Plan** and provide **Proof of Loss** documentation supporting its determination based upon the standards defined above. We reserve the right to investigate and make any final determination of what is **Experimental and/or Investigational** or **Medically Necessary** and eligible for indemnification under this **Policy** prior to reimbursement.

d. **Usual, Reasonable and Customary ("URC")** charges are determined by the **Administrator** utilizing national and regional industry data, Medicare data, or other similar sources of medical cost data. The **URC** charges shall be based upon the:

i. complexity of the **Treatment**;

ii. the skill of the medical provider or physician;

iii. the intensity of medical service utilized; and

iv. the geographical standards for service and pricing.

We reserve the right to perform bill audit prior to payment of the provider by the **Administrator** and prior to reimbursement, if any, under this **Policy**. We will reimburse the lesser of eligible **URC**, billed charges, or the negotiated rate.

6. **ALTERNATIVE CARE**. **Treatments** of **Alternative Care** may be deemed eligible expenses under this **Policy** when all of the following criteria have been satisfied and evidence thereof has been remitted to us for approval:

a. You demonstrate to our satisfaction that providing the **Alternative Care** resulted in a cost savings to the **Plan**;

b. The **Alternative Care** was recommended by case management provider servicing your **Plan**;

c. The **Alternative Care** was **Medically Necessary**;

d. The **Alternative Care** replaces a **Treatment** that would be covered under your **Plan**;

e. The **Alternative Care** expenses do not exceed the maximum allowed under your **Plan** for the **Treatment** replaced by the **Alternative Care**; and

f. The **Alternative Care** was provided with the consent of the **Person**, or his or her legal representative.

If the **Alternative Care** is provided in lieu of inpatient hospitalization, the **Person** must meet utilization review criteria satisfactory to us for inpatient hospitalization for the entire period the **Alternative Care** is provided. In no event will **Alternative Care** that exceeds ninety (90) days be considered an eligible expense unless approved in writing by us.

7. **FIFTY PERCENT RETENTION AND MAJOR DIAGNOSIS NOTICE REQUIREMENTS**. You or the **Administrator** will give us written notice (in a form satisfactory to us) within thirty (30) days after a **Loss** for any covered **Person** exceeds fifty percent (50%) of the Retention shown in Schedule Item 6(b), or when any covered **Person** has been diagnosed with a medical condition that has been identified in the Major Diagnosis **Endorsement** attached to this **Policy**.

8. **LITIGATION OR OTHER LEGAL EXPOSURES**. You or the **Administrator** will give us written notice, within ten (10) days, of any lawsuit, threatened lawsuit, or other formal proceeding against the **Plan** which may result in a **Loss** under this **Policy**.

9. **LATE REPORTING PENALTY**. If we do not receive a request for reimbursement within one hundred twenty (120) days after a **Loss**, exceeding the Specific Retention, is **Paid** by you or the **Administrator**, we will reduce our indemnity due under this **Policy** by twenty-five percent (25%). Proof of prejudice is not required in our utilization and enforcement of this late reporting penalty.

10. **AGGREGATE EXCESS REPORT**.

    a. You or the **Administrator** will send us an Aggregate Excess Report (in a form satisfactory to us), within twenty (20) days after the end of each calendar month during the **Policy Period**, containing the following data:

        i. The number of **Employees** in each **Covered Unit** who are covered by the **Plan** as of the first day of the reporting month; and

        ii. The total amount of **Losses** for all covered **Persons** during the reporting month.

    b. Reported **Losses** must be within the **Loss Limit Per Person** shown in Schedule Item 7(b).

    c. This report will identify and segregate **Losses** by each **Covered Unit**.

11. **PROOF OF LOSS**.

    a. **SPECIFIC EXCESS CLAIMS**. We will reimburse you for a **Loss** covered by the **Policy** after we receive satisfactory **Proof of Loss**, as solely defined by us, that you or the **Administrator** has **Paid** the **Loss**. Satisfactory **Proof of Loss** of a Specific Excess claim includes, but is not limited to:

        i. our completed loss advice form;

        ii. proof of eligibility under the **Plan**;

        iii. claim payment report with the following data: provider of services, **Incurred** from and to dates, service/procedure codes, billed amounts, **Paid** amounts, **Paid** dates, and check numbers;

        iv. itemized medical bills (as applicable);

        v. invoices from managed care and other cost containment vendors:

        vi. comprehensive case management reports with updates;

        vii. attending physician statements and medical narratives;

        viii. date the accident occurred or date the sickness was diagnosed; and

ix. date that medical care was first received.

b. **AGGREGATE EXCESS CLAIM**. After the end of the **Policy Period**, we will reimburse you for **Losses** covered by this **Policy** after we receive satisfactory **Proof of Loss** that you or the **Administrator** has **Paid** the **Loss**. You or the **Administrator** must provide us with **Proof of Loss** within ninety (90) days after the end of the period shown in Schedule Item 7(a)(2) in order for us to consider reimbursing an Aggregate Excess claim. Satisfactory **Proof of Loss** of an Aggregate Excess claim includes, but is not limited to:

i. our completed loss advice form;

ii. computer reports of total **Paid** claims (month-by-month) during the **Policy Period** showing claimant, **Incurred** date, service/procedure code, billed amount, **Paid** date, provider and amount **Paid**;

iii. computer reports showing total **Employee** census information (month-by-month) during the **Policy Period**; and

iv. documentation showing any voided payments, refunds, or other adjustments.

c. **ADDITIONAL DOCUMENTATION**. If we ask for **Loss** documentation that is not described in subsections a. or b. above, you agree to provide or require your **Administrator** to provide such documentation to us. It is your responsibility and financial obligation to provide us with satisfactory **Proof of Loss**.

12. **CLAIMS APPEAL PROCESS**. You may appeal any claim determination made by us under this **Policy** by submitting a written appeal within ninety (90) days from the date of our initial claim determination. Your written appeal must clearly state the basis of your disagreement with our claim determination and include all relevant documentation in support of your appeal that has not been previously provided to us.

Any appeal of a claim determination made by us on the grounds that the **Treatment** provided was either (i) not **Medically Necessary**; (ii) Cosmetic, Custodial in Nature, or Unproven; or (iii) **Experimental and/or Investigational**, must include a report from an **Independent Medical Review**. The **Independent Medical Review** report will be obtained at your expense. The utilized independent review organization must be mutually acceptable to you and us.

SECTION EIGHT: RENEWAL AND CANCELLATION

1. **RENEWAL**. In order for us to offer you a renewal for succeeding **Policy Periods**, you must provide us the following information at least three (3) months prior to the end of the **Policy Period**:

a. a list of every **Employee** and the eligible dependents of each **Employee**, identified by the applicable **Covered Unit**, showing each **Person's** age, gender, and rating classification;

b. the total number of **Employees** working within each U.S. Postal Service Zip Code area for each **Covered Unit**;

c. the applicable PPO network for each **Employee**;

d. a report summarizing claims, segregated by the applicable **Covered Unit**, which exceed, or may exceed, fifty percent (50%) of the Retention for each **Person** shown in Schedule Item 6(b), or any **Persons** who have been diagnosed with a condition listed in the Major Diagnosis **Endorsement** attached to this **Policy**. The report will also identify any pending, denied, or claims placed on hold by you or your **Administrator** for the prior twelve (12) months;

e. a report summarizing aggregate month-by-month paid claims for all covered **Persons** along with monthly census and any specific claims excess of the Loss Limit Per Person;

f. any **Plan Change(s)** that are being considered by you; and

g. any other information we may request.

2. **NONRENEWAL**. If we elect not to renew this **Policy**, we will give you written notice by registered mail at least thirty (30) days, or longer if required by law, prior to the end of the **Policy Period** stating our reason for the nonrenewal.

3. **CANCELLATION**.

a. You may cancel this **Policy** at any time by giving us thirty (30) days advance written notice stating the cancellation date.

b. We may cancel this **Policy** as of:

i. The date your contract between you and the **Administrator** is cancelled, unless we give written consent and approve the replacement **Administrator**, if any;

ii. The date your **Plan** is terminated;

iii. The date in which premium was due but has not been paid by you within the Grace Period (pursuant to Section Two: Premium, Items 3 and 4);

iv. The first day of the month in which the number of covered **Employee**s falls below one hundred (100) lives; or

v. The sixty-first (61st) day following issuance of notice by us to you for your failure or the failure of your **Administrator** to satisfy your obligations under this **Policy**, and such obligation had not been subsequently remedied.

c. Notice of cancellation by either party to the other will be given by registered mail, or as may be required by applicable law, stating the cancellation date.

4. **TERMINATION OF COVERAGE**. In the event this **Policy** is cancelled by you or by us pursuant to Item 3 above, and prior to the expiration of the **Policy Period**, as defined in Schedule Item 4, the following **Policy** terms will be revised to reflect the notified **Policy** cancellation date:

a. Schedule Item 4 – **Policy Period** end date;

b. Schedule Item 6(a)(1) – Specific Excess, Liability Basis, Claims Incurred end date;

c. Schedule Item 6(a)(2) – Specific Excess, Liability Basis, Claims Paid end date;

d. Schedule Item 7(a)(1) – Aggregate Excess, Liability Basis, Claims Incurred end date, if applicable; and

e. Schedule Item 7(a)(2) – Aggregate Excess, Liability Basis, Claims Paid end date, if applicable.

SECTION NINE: GENERAL PROVISIONS

1. **BANKRUPTCY**. Your bankruptcy will not relieve us from the payment of any claim covered by this **Policy**. Nothing in the **Policy** will increase our liability under the **Policy** beyond that which it would otherwise be if you had not become insolvent or bankrupt.

2. **INSPECTION OF RECORDS**. We or our representatives have the right (at no cost to us) to inspect any books, records or other documentation applicable to the **Plan** which are kept by you and/or the **Administrator**. The inspection may be made by us or our representatives at any time during the normal business hours of the organization where the inspection takes place.

3. **LEGAL ACTION**. No action at law or in equity will be brought against us to recover on this **Policy** prior to the expiration of sixty (60) days after written **Proof of Loss** has been furnished in accordance with the requirements of this **Policy**. No such action will be brought more than two (2) years after the time written **Proof of Loss** is required to be furnished.

4. **SUBROGATION AND RIGHT OF RECOVERY**. You agree to prosecute any and all valid claims against any third party that may arise from any claim for which **Benefits** were **Paid** under the **Plan**. You or the **Administrator** will notify us of any subrogation claims and will account to us for any **Losses** recovered. If you or the **Administrator** fails to pursue any action against any third party and you have received, or are entitled to receive, reimbursements from us for **Benefits Paid** under the **Plan**, we will be subrogated to your rights and the rights of any **Person** under the **Plan**. We have the right of recovery to any amounts you or any **Person** receiving **Benefits** under the **Plan** recover from any third party who is found liable for these amounts. You will do everything necessary to protect these rights and to help us enforce them. The recovered **Loss** remaining after deducting the expenses of our recovery will first be used to reduce our **Loss**; then we will pay the balance, if any, to you.

5. **CLERICAL ERROR**. This **Policy** will not be invalidated or terminated by clerical error or mutual mistake. Clerical error or mutual mistake will not continue this **Policy** if it has been terminated, and it will not expand our obligations under this **Policy**. Upon discovery of such clerical error, the **Policy** will be restored and amended to reflect the terms and conditions that were agreed to at the time of its execution.

6. **OTHER INSURANCE**. If any other insurance exists protecting you against **Loss** covered by this **Policy**, this **Policy** will apply in excess of the other insurance.

7. **PARTIES**. We are the Insurer under this **Policy** and you are the Insured. **Employees** and their dependents are not parties to this **Policy**. We do not insure or pay **Benefits** to your **Employees** or their dependents under the **Plan**. We are limited under the **Policy** to reimbursing you for **Losses** under this **Policy** that are **Incurred** and **Paid** by you as self-insurer of the **Plan**.

8. **REPRESENTATIONS**. We issued and may renew this **Policy** relying upon the information furnished us as to the number of your **Employees** and the claims experience under the **Plan**. If the initial or renewal underwriting information is incorrect or incomplete, we have the right to amend the **Schedule** to reflect what we would have shown in the **Schedule** using the accurate and complete information. This amendment will be effective at the beginning of the **Policy Period** in which we learn of the incorrect or incomplete information.

9. **REFUND OF OVERPAYMENTS**. If we, you or the **Administrator** determine that we have overpaid under this **Policy** due to a claim credit which may be the result of a coordination of benefits change, a subrogation recovery, an audit or billing/payment error or other circumstance, then you will promptly refund such overpayment to us within sixty (60) days of discovery of the overpayment. We reserve the right to recover such overpayments from future claim payments due under this **Policy** if a refund payment is not received within sixty (60) days. If no future claim payments are due and the refund of an overpayment is not made by you, then we may take legal action to collect such overpayment. You agree to indemnify us for any cost of collection, including but not limited to, attorney's fees and court cost.

10. **SELF-INSURANCE**. You are now and will remain until the end of the **Policy Period** self-insured for the **Benefits** provided by the **Plan**. It is your responsibility to make all filings required by federal and state authorities regulating self-insured plans.

11. **TRANSFER**. Your rights or duties under this **Policy** may not be transferred or assigned to anyone else without our written consent.

12. **CHANGES**. Notice to or knowledge possessed by any agent, broker, or other person shall not effect a change or waiver of any part of this **Policy**, nor prevent us from asserting any rights under this **Policy**. No part of this **Policy** can be changed or waived, except by written **Endorsement** issued by us.

13. **HEADINGS**. The descriptions in the headings and sub-headings of this **Policy** are solely for convenience, and form no part of the terms and conditions of coverage.

14. **ENTIRE AGREEMENT**. The parties agree that this **Policy**, including the **Schedule**, the Disclosure Statement, the Binder, the **Plan**, Exhibits, and any **Endorsements**, constitutes the entire agreement between you and us relating to this **Policy**.

We executed this **Policy** by printing the facsimile signatures of our President and Secretary on the attached signature page and by the actual signature of the authorized North American Specialty Insurance Company representative on the **Schedule**.

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC NO LASER RATE CAP (NLRC) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

In consideration for the assessment of the No Laser Rate Cap (NLRC) premium factor as stated within the Binder for Excess Medical Indemnity Coverage (Binder) of the **Policy**, we agree that at the time of renewal of your **Policy** with us for the next **Policy Period**, your **Policy** will not contain any ***additional*** **Persons** with Specific Excess Retentions, as listed in Schedule Item 6(b). We reserve the right to carry over to the renewal **Policy** any or all **Persons** that already have a Specific Excess Retention as listed within the Binder of the **Policy**.

In addition, the Specific Excess Premium rates of the renewal **Policy**, as listed in Schedule Item 6(g), will not be increased more than forty-five percent (45%) over the Specific Excess Premium rates of the current **Policy**.

If your **Policy** reflects the application of an Aggregating Specific Retention Option via an **Endorsement**, the amount of the Aggregating Specific Retention on your renewal **Policy** will also increase by the same percentage as that of the Specific Excess Premium rates.

We reserve the right to change, modify or cancel this **Endorsement**, at our sole discretion, should you amend or change your **Plan** in any way that materially affects our risk or liability with regards to the **Policy** or this **Endorsement**, or if your renewal **Policy**:

1. Contains a **Policy Period** that is longer in duration than the **Policy Period** listed in the Schedule Item 4 of the current **Policy**; or

2. Contains coverage for Retirees, as listed in Schedule Item 6(e) Covered Unit(s), if coverage for Retirees was not previously purchased with the current **Policy**; or

3. Contains a different list of Specific Benefits Covered than what is listed in the Binder of the current **Policy**; or

4. Contains a Specific Excess Retention amount that is not equal to the Specific Excess Retention amount listed in Schedule Item 6(b) of the current **Policy**; or

5. Contains a Specific Excess Liability Basis that is not identical to the Specific Excess Liability Basis listed in Schedule Item 6(a) of the current **Policy**; or

6. Contains a Specific Excess Annual Policy Period Limit that is higher than the Specific Excess Annual Policy Period Limit listed in Schedule Item 6(d) of the current **Policy**; or

7. Contains a Specific Excess Indemnity Percentage that is higher than the Specific Excess Indemnity Percentage listed in Schedule Item 6(c) of the current **Policy**.

If your **Policy** reflects the application of the Aggregating Specific Retention Option, we reserve the right to change, modify or cancel this **Endorsement** if you:

1. Cancel the Aggregating Specific Retention Option on any renewal **Policy**, or

2. Request the Aggregating Specific Retention to be decreased on any renewal **Policy**; or

3. Request the Aggregating Specific Retention to be increased by a percentage less than the increase of the Specific Excess Premium rates as allowed by this **Endorsement**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADD PLAN ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, the following **Plan** is added to Schedule Item 5. as follows:

5. **PLAN NAME**:

A copy of the new **Plan** is attached to this **Policy** as Exhibit ____.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADDRESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 2. Address is deleted and replaced with the following:

2. **ADDRESS**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADMINISTRATOR ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 8. Administrator is deleted and replaced with the following:

8. **ADMINISTRATOR**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE INDEMNITY LIMIT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(e) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

e. Indemnity Limit:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(d) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

d. Indemnity Percentage:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(a) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE MONTHLY PREMIUM RATE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(h) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

h. Monthly Premium Rate:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATING SPECIFIC RETENTION OPTION ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. Schedule Item 6. Specific Excess is amended by adding the following:

6. **SPECIFIC EXCESS**:

h. Aggregating Specific Retention. In addition to retaining the Specific Retention each Person amount for each **Loss Incurred** under this **Policy**, as defined in Schedule Item 6(b), you also agree to retain the following Aggregating Specific Retention amount for all **Persons** with a **Loss** under this **Policy**:

Only those amounts of the **Losses** exceeding the Specific Retention each Person will be aggregated to satisfy the Aggregating Specific Retention amount. We will not indemnify you on a specific **Loss** prior to your reaching the above defined Aggregating Specific Retention amount.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ANNUAL PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

It is agreed that the **Policy** is hereby amended as follows:

I. Section Two: Premium is hereby deleted in its entirety and replaced by the following:

SECTION TWO: **PREMIUM**

1. **DEPOSIT PREMIUM**. A deposit premium of $_____ is due on the first day of the **Policy Period**.

2. **CENSUS REPORT**. Within twenty (20) days after the end of the **Policy Period**, you must send us a census report showing the number of **Employees** within each rating classification shown in Schedule Item 6(g) who were covered by the **Plan** on the first day of each month in the **Policy Period**.

3. **FINAL PREMIUM**. The final premium due for the **Policy Period** shall be determined by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan**.

4. **ADJUSTMENT PREMIUM**. At the end of the **Policy Period**:

   a. if the final premium is more than the deposit premium, you will send us your payment of the difference along with the Census Report; or

   b. if the final premium is less than the deposit premium, we will return the difference to you promptly after we receive the Census Report.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ATTACHMENT POINT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(c) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

c. Attachment Point:

(1) Estimated Attachment Point:

(2) Factor:

(3) Minimum Attachment Point:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

COVERED UNIT(S)
SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Items 6(e) and 7(f) are deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

e. Covered Unit(s):

7. **AGGREGATE EXCESS**:

f. Covered Unit(s):

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

COVERED UNIT(S)
SPECIFIC EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(e) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

e. Covered Unit(s):

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

DELETE PLAN ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, the following **Plan** is deleted from Schedule Item 5:

5. **PLAN NAME**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

INSURED ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 1. Insured is deleted and replaced with the following:

1. **INSURED**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGREGATE LOSS LIMIT PER PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(b) is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

b. Loss Limit Per Person:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

MONTHLY AGGREGATE REIMBURSEMENT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

I. Section One: Definitions is amended by adding Item 25. Monthly Attachment Point as follows:

25. **MONTHLY ATTACHMENT POINT** shall mean the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month of the **Policy Period** multiplied by the Factor as stated in Schedule Item 7(c)(2). The **Monthly Attachment Point** is cumulative for each month of the **Policy Period**, meaning that the **Monthly Attachment Point** for each prior month is added together to determine the current **Monthly Attachment Point**.

II. Section Four: Aggregate Excess is hereby amended by adding Item 6. Monthly Aggregate Reimbursement as follows:

6. **MONTHLY AGGREGATE REIMBURSEMENT.** Subject to all other provisions of the **Policy**, we will reimburse you for **Loss** during the **Policy Period** in excess of the **Monthly Attachment Point** subject to the following conditions:

a. For the first three months of the **Policy Period**, no monthly aggregate reimbursements will be made to you.

b. After the end of the fourth month of the **Policy Period**, and at the end of each subsequent month of the **Policy Period**, we will reimburse you the amount of **Loss** which exceeds the cumulative **Monthly Attachment Point**, but only if the **Loss** exceeds the **Monthly Attachment Point** by at least $5,000 (USD).

c. The **Loss** will be paid to the **Administrator** within fifteen (15) business days after the requirements of Section Seven: Claims, Item 10, Aggregate Excess Report, Item 11(b) Proof of Loss, Aggregate Excess Claims, and Item 11(c), Proof of Loss, Additional Documentation, have been satisfied by you.

d. After the end of the **Policy Period**, if your total **Loss** does not exceed the **Minimum Attachment Point**, as defined in Schedule Item 7(c)(3), you will reimburse us the total amount of **Loss** paid to you via the monthly aggregate reimbursements within fifteen (15) business days after you or the **Administrator** receives our demand for reimbursement. Failure to reimburse us within fifteen (15) business days will result in a two percent (2%) per month penalty until such amounts are paid in full.

e. After the end of the **Policy Period,** if the total amount of **Loss** paid to you during the **Policy Period** is greater than the total **Loss** due to you under Section Four: Aggregate Excess, Item 2. Aggregate Excess Indemnity for the **Policy Period**, you will reimburse us the difference within fifteen (15) business days after you or the **Administrator** receives our demand for reimbursement. Failure to reimburse us within fifteen (15) business days will result in a two percent (2%) per month penalty until such amounts are paid in full.

f. If the **Policy** terminates prior to the end of the **Policy Period**, then you or the **Administrator** must reimburse us the total amount of **Loss** paid to you within fifteen (15) business days after the termination date. Failure to reimburse us will result in a two percent (2%) per month penalty until such amounts are paid in full.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

NON-MEDICAL BENEFITS COVERED
SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Items 6(f) and 7(g) are deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

f. Non-medical Benefits covered:

7. **AGGREGATE EXCESS**:

g. Non-medical Benefits covered:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

NON-MEDICAL BENEFITS COVERED
SPECIFIC EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(f) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

f. Non-medical Benefits covered:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

PARTICIPANT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

I. Section One: Definitions, Item 6. Employee is deleted in its entirety and replaced by the following:

6. **Participant** means any individual who is employed by or otherwise participates in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired P**articipants** or the dependents of retired **Participants** unless otherwise agreed to by us.

II. Throughout this **Policy**, the term "**Employee**" is hereby deleted and replaced with the term "**Participant**."

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

PLAN NAME ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 5. Plan Name is deleted and replaced with the following:

5. **PLAN NAME**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

POLICY PERIOD ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 4. Policy Period is deleted and replaced with the following:

4. **POLICY PERIOD**:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

QUARTERLY PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

I. Schedule Item 6. Specific Excess, subsection g. Premium is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

g. Premium:

Rating Classification	**Quarterly Rate**

II. Schedule Item 7. Aggregate Excess, subsection h. Monthly Premium Rate is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

h. Quarterly Premium Rate:

II. Section Two: Premium is deleted in its entirety and replaced with the following:

SECTION TWO: PREMIUM

1. **CALCULATION**. The premium for each three months under the **Policy Period** ("Policy Quarter") that is due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the first day of each Policy Quarter.

2. **DUE DATE AND QUARTERLY REPORT**. Premium is due on the first day of each Policy Quarter during the **Policy Period**. Each premium payment must be accompanied by a report showing the total number of **Employees** as of the first day of each Policy Quarter covered under the **Policy**. If your **Policy** has more than one Rating Classification, as stated in Schedule Items 6(g), then your report should also reflect a breakout of **Employee** numbers per Rating Classification.

3. **GRACE PERIOD**. A Grace Period of thirty-one (31) days following the premium due date will be granted for the payment of each quarterly premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period.

4. **NON-PAYMENT**. Failure to pay in full the Policy Quarter premium within the Grace Period will cancel the **Policy** as of the premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full Policy Quarter premium is not paid prior to the expiration of the Grace Period.

5. **REINSTATEMENT**. If any Policy Quarter premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate the **Policy** on the terms and conditions that we select at that time.

6. **ADJUSTMENTS.** If you pay any Policy Quarter premium in excess of the amounts due, you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next quarterly premium payment due. A request for refund or a claim offset for a future quarterly premium payment must be given to us in writing, stating the basis and calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the Policy Quarter premium payment amount was adjusted. No Policy Quarter premium adjustments will be allowed after ninety (90) days following the conclusion of the **Policy Period**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC RETENTION EACH PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(b) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

b. Retention each Person:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC EXCESS PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(g) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

g. Premium:

Rating Classification	**Monthly Rate**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(c) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

c. Indemnity Percentage:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(a) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

MAJOR DIAGNOSIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that this Policy is hereby amended as follows:

Pursuant to Section Seven: Claims, Item 7, you or the **Administrator** will give us written notice if any covered **Person** has been diagnosed with any of the following ICD-9 Codes or Diagnoses identified in Item I below or otherwise identified in Item II below:

I.	**Diagnoses**	**ICD-9 Codes**
	Accidental Injury classified with an "E" code.	Any "E" code
	AIDS	042
	Alpha 1 (Antitrypsin Deficiency)	277.6
	Amyloidosis	277.3
	Anterior Horn Cell Disease	335.2
	Blood Disorder (Hemophilia, aplastic anemia sickle cell, primary thrombocytopenia, etc.)	286-287.9
	Burn - Severe	941-949
	Cancer, Leukemia, Lymphoma, etc.	140-239.9
	Cardiomyopathy	425
	Cerebral Vascular Disease/Stroke	430-438
	Chronic Inflammatory Demylinating Polyneuropathy (CIDP)	356
	Congenital Anomalies/Premature Infants	740-779.9
	Cystic Fibrosis	277
	Gaucher's Disease	272.7
	Heart/Lung Disease	416-429
	Hepatitis	070
	High Risk Pregnancy	640-648, 651, V23.4
	Liver Disease	570-573
	Multiple Sclerosis	340
	Nervous System Disorder	320-389
	Pancreatitis	577
	Renal Disease	584-587
	Respiratory Problem	416 480-482, 496, 513-516, 519
	Traumatic Injury - Major (spinal cord, head, trauma, etc.)	800-809, 828-829, 850-54, 860-871, 873-875, 885-887, 895-897, 900-904, 925-929, 952-953

II. ALSO IDENTIFY ANY OF THE FOLLOWING:

- Potential transplants, except cornea (Including transplant rejection or complications).
- Any **Person** with three (3) or more admissions in a six (6) month period.
- Any **Person** with one (1) hospitalization of seven (7) days or more.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

Schedule Item 6(a) will be amended to reflect the following liability basis for your Specific Excess coverage.

SCHEDULE OF INSURANCE

6. **SPECIFIC EXCESS**

   a. Liability Basis:

      (1) Claims Incurred from _____ through _____

      (2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

Schedule Item 7(a) will be amended to reflect the following liability basis for your Aggregate Excess coverage. Schedule Item 7(c) will be amended to reflect your revised Attachment Point criteria.

SCHEDULE OF INSURANCE

7. **AGGREGATE EXCESS**:

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

c. Attachment Point:

(1) Estimated Attachment Point

(2) Factor:

(3) Minimum Attachment Point:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

MEDICARE BENEFITS EXCLUSION ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that this **Policy** is hereby amended as follows:

I. As of the effective date of this **Endorsement**, Section Six: Exclusions, Item 1(p) is deleted and replaced with the following:

1. **THIS POLICY DOES NOT APPLY**:

p. to Medicare **Benefits** and any **Benefits** which would have been covered by Medicare if not for the fact that the **Person** either i) failed to enroll for Medicare coverage on the earliest possible date entitled, or ii) failed to maintain Medicare coverage previously in force.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

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OTHER CARRIER TRANSPLANT COVERAGE

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

I. As of the effective date of this Endorsement, Section Six: Exclusions, Item 1(y) is added as follows:

1. THIS POLICY DOES NOT APPLY:

y. to transplant and transplant related charges **Incurred** during the **Policy Period** if you have purchased a transplant medical indemnity policy through another carrier whose policy covers a period of time coinciding, in total or partially, with the **Policy Period** of this **Policy**. However, our **Policy** will cover such transplant and transplant related charges if a) the **Person** is excluded due to the other carrier's transplant policy pre-existing conditions terms, or b) the transplant and transplant related expense(s) are **Incurred** outside of the other carrier's transplant benefit period as defined by that policy, but with within our **Policy Period**. You will provide us with a copy of the other carrier's transplant medical indemnity policy, including all endorsements, for qualification and adjudication of eligible claims under the **Policy**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

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President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC POLICY PERIOD LIMIT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

I. As of the effective date of this **Endorsement**, Schedule Item 6(d) Policy Period Limit is deleted and replaced with the following:

SCHEDULE OF INSURANCE

6. **SPECIFIC EXCESS:**

d. Policy Period Limit:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective **Policy No.**

Named Insured

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

President Secretary

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*		
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	01/31/2012

Comments:

Application, SP 4 291AR 0608 NAS, was filed and approved under Our Filing Number NAS-ESL-AR-08-03025-1-F.

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	01/31/2012

Comments:

Attachment:

AR NAS Flesch Score Certification.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Forms Memo & Side-By-Side Comparisons	Approved-Closed	01/31/2012

Comments:

Attachments:

AR NAS Explanation of General Endorsements.pdf
SP 001 210 vs SP 5 150.pdf
SP 001 211 vs SP 5 151.pdf
SP 001 212 vs SP 5 152.pdf
SP 001 213 vs SP 5 165.pdf
SP 001 214 vs SP 5 157.pdf
SP 001 215 vs SP 5 159.pdf
SP 001 216 vs SP 5 160.pdf
SP 001 218 vs SP 5 162.pdf
SP 001 219 vs SP 5 153.pdf
SP 001 220 vs SP 5 154.pdf
SP 001 221 vs SP 5 176.pdf
SP 001 222 vs SP 5 163.pdf
SP 001 223 vs SP 5 155.pdf
SP 001 224 vs SP 5 177.pdf

SERFF Tracking Number:	*ERCB-127970774*	*State:*	*Arkansas*
Filing Company:	*North American Specialty Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AS-ESLE-AR-11-06350-1-F*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing*		
Project Name/Number:	*AR - NAS- ESL - Stop Loss Program - Ehanced Forms Filing/NAS-ESLE-AR-11-06350-1-F*		

SP 001 226 vs SP 5 164.pdf
SP 001 227 vs SP 5 167.pdf
SP 001 228 vs SP 5 170.pdf
SP 001 229 vs SP 5 172.pdf
SP 001 230 vs SP 5 156.pdf
SP 001 231 vs SP 5 175.pdf
SP 001 232 vs SP 5 174.pdf
SP 001 233 vs SP 5 340.pdf
SP 001 234 vs SP 5 338.pdf
SP 001 236 vs SP 5 117.pdf
SP 001 237 vs SP 5 173.pdf
SP 001 238 vs SP 5 158.pdf
SP 001 241 vs SP 5 168.pdf
SP 001 242 vs SP 5 161.pdf
SP 001 247 vs SP 5 337.pdf
SP 001 248 vs SP 5 169.pdf

FLESCH SCORE CERTIFICATION

I, Giuseppe LePera, Vice President of North American Specialty Insurance Company, do certify that the forms contained in this filing meet the minimum reading ease score on the Flesch Reading Ease. The Flesch score for the policy form was 49. The averaged Flesch Reading Ease score on the endorsements was 57.

Giuseppe LePera, Vice President
North American Specialty Insurance Company
650 Elm Street
Manchester, NH 03101

North American Specialty Insurance Company
Excess Medical Indemnity Policy
Excess Stop Loss Enhanced Program
Explanation of General Endorsements

SP 5 149 - No Laser Rate Cap (NLRC) Endorsement - This is an optional endorsement that will be attached to the Policy if the self-insured employer wants to set a higher specific retention level for a unique situation, choosing to absorb more of the costs himself for a particular risk.

SP 5 150 - Add Plan Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add another self-insured employee benefit Plan onto coverage in mid-Policy Period. For example, at mid Policy Period, the employer offers a Long Term Care benefit Plan to certain high level employees. This endorsement replaces SP 001 236 1100 NAS.

SP 5 151 - Address Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer's address to be changed in mid-Policy Period. This endorsement replaces SP 001 211 1100 NAS.

SP 5 152 - Administrator Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to name a new Administrator in mid-Policy Period. This endorsement replaces SP 001 212 1100 NAS.

SP 5 153 - Aggregate Indemnity Limit Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Indemnity Limit as provided in Section Four Aggregate Excess paragraph 4 in mid-Policy Period. This endorsement replaces SP 001 219 1100 NAS.

SP 5 154 - Aggregate Indemnity Percentage Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Indemnity Percentage as provided in Section Four Aggregate Excess Paragraph 2 in mid-Policy Period. This endorsement replaces SP 001 220 1100 NAS.

SP 5 155 - Aggregate Liability Basis Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Liability Basis in mid-Policy Period. This endorsement replaces SP 001 223 1100 NAS.

SP 5 156 - Aggregate Monthly Premium Rate Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Monthly Premium Rate in mid-Policy Period. This endorsement replaces SP 001 230 1100 NAS.

SP 5 157 - Aggregating Specific Retention Option Endorsement - In addition to the Specific Retention each Person indicated in Schedule Item 6(b), the Employer must also satisfy an aggregate retention for all Persons covered under the Policy. This acts as a second retention. This amount varies based on the size of the group and the specific retention amount. This endorsement replaces SP 001 214 1100 NAS.

SP 5 158 - Annual Payment of Premium Endorsement - Under section two of the Policy, premium is Paid on a monthly basis. This Endorsement permits the Employer to remit premium on an annual basis for payment of a deposit Premium on the first day of the Policy Period. This endorsement replaces SP 001 238 1100 NAS.

SP 5 159 - Attachment Point Endorsement - A new Schedule is issued with respect to each new Policy Period. This endorsement permits the employer to change the Attachment Point in mid-Policy Period, subject to applicable state regulations. This endorsement replaces SP 001 215 1100 NAS.

SP 5 160 - Covered Unit(s) Specific and Aggregate Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add additional or delete existing Covered Units for Aggregate and Specific Excess in mid-Policy Period. A Covered unit is a particular class of Employees (and the eligible covered dependents of the Employees under the Plan) who are covered under the Plan and indemnified by the Policy. A Covered Unit may be identified by company name, division, location or group. This endorsement replaces SP 001 216 1100 NAS.

SP 5 161 - Covered Units Specific Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add additional or delete existing Covered Units for Specific Excess in mid-Policy Period. A Covered unit is a particular class of Employees (and the eligible covered dependents of the Employees under the Plan) who are covered under the Plan and indemnified by the Policy. A Covered Unit may be identified by company name, division, location or group. This endorsement replaces SP 001 242 1100 NAS.

SP 5 162 - Delete Plan Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to delete a self-insured employee benefit Plan from coverage in mid-Policy Period. This endorsement replaces SP 001 218 1100 NAS.

SP 5 163 - Insured Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the named Insured in mid-Policy period. Such a change may be necessary, due to a business entity change, such as a merger or acquisition or a business name change. This endorsement replaces SP 001 222 1100 NAS.

SP 5 164 - Aggregate Loss Limit Per Person Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Loss Limit Per Person in mid-Policy Period. This endorsement replaces SP 001 226 1100 NAS.

SP 5 165 - Monthly Aggregate Reimbursement Endorsement - Paragraph 11 (b) of Section Seven, Claims provides that Westport will reimburse the Employer after the end of the Policy Period for any Aggregate Excess losses. This Endorsement permits Westport to reimburse the Employer for any Aggregate Excess Losses that exceed the Monthly Attachment Point at the end of each month of the Policy Period. At the end of the Policy Period any Losses Paid under this Endorsement are reconciled with any Aggregate Excess Losses which would have been Paid under Section Seven (b) of the Policy. This endorsement replaces SP 001 213 1100 NAS.

SP 5 167 - Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Non-Medical Benefits Covered under the Aggregate and Specific Excess in mid-Policy Period. This endorsement replaces SP 001 227 1100 NAS.

SP 5 168 - Non-Medical Benefits Covered Specific Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Non-Medical Benefits Covered under the Specific Excess in mid-Policy Period. This endorsement replaces SP 001 241 1100 NAS.

SP 5 169 - Participant Endorsement - Most policies will be issued to self-insured Employers. However, certain Policies may be issued to Associations or other groups in which the Employer/Employee relationship is not as well defined. This Endorsement substitutes the term "Participant" for "Employee" in order to eliminate any inconsistencies. This endorsement replaces SP 001 248 1100 NAS.

SP 5 170 - Plan Name Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Plan Name in mid-Policy Period. Such a change may be necessary, due to a business entity change, such as a merger or acquisition or a business name change. This endorsement replaces SP 001 228 1100 NAS.

SP 5 172 - Policy Period Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Policy Period in mid-Policy Period. This endorsement replaces SP 001 229 1100 NAS.

SP 5 173 - Quarterly Payment of Premium Endorsement - Under Section two of the Policy, Premium is Paid on a monthly basis. This Endorsement permits the Employer to remit premium on a quarterly (every 3 months) basis. This endorsement replaces SP 001 237 1100 NAS.

SP 5 174 - Specific Retention Each Person Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the retention each Person in mid-Policy Period subject to applicable state regulations. This endorsement replaces SP 001 232 1100 NAS.

SP 5 175 - Specific Excess Premium Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer and Westport to change the Specific Premium in mid-Policy Period due to changes in retention levels, Employees and/or Covered Units eligible for coverage under the Plan. This endorsement replaces SP 001 231 1100 NAS.

SP 5 176 - Specific Indemnity Percentage Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Indemnity Percentage as stated under Section three (2) Indemnity in mid-Policy Period. This endorsement replaces SP 001 221 1100 NAS.

SP 5 177 - Specific Liability Basis Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Liability Basis in mid-Policy Period. This endorsement replaces SP 001 224 1100 NAS.

SP 5 338 - Specific Terminal Liability Option Endorsement - Provides 3 months of paid claim run-out protection on the specific coverage in the event the employer terminates their policy. The claims must be incurred prior to the end of the policy period. This endorsement replaces SP 001 234 1100 NAS.

SP 5 340 - Aggregate Terminal Liability Option Endorsement - Provides 3 months of paid claim run-out protection on the aggregate in the event that the employer terminates their stop loss policy. The claims must be incurred prior to the end of the policy period. This endorsement replaces SP 001 233 1100 NAS.

SP 5 342 - Medicare Benefits Exclusion Endorsement - This endorsement clarifies the Medicare benefits exclusion contained within the policy. As this form is adding clarification to an existing exclusion, there is no rate impact. This endorsement replaces SP 001 213 1100 NAS.

SP 5 343 - Other Carrier Transplant Coverage - Provides instruction as to coverage for organ transplants when there is an existing transplant medical indemnity policy through another carrier that covers a period of time coinciding with the Policy Period of the Westport policy.

SP 5 344 - Specific Policy Period Limit Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Policy Period Limit as stated under Section Three in the policy.

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADD PLAN ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As ~~respects accidents taking place and sicknesses diagnosed on or after~~of the effective date of this **Endorsement**, the following **Plan** is added to Schedule Item 5. as ~~Exhibit ___~~:follows:

5. **PLAN NAME**:

A copy of the new **Plan** is attached to this **Policy** as Exhibit ____.

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADDRESS ENDORSEMENT

~~Schedule Item 2~~**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended ~~to read~~ as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 2. Address is deleted and replaced with the following:

2. **ADDRESS**:~~–~~_____

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~ **NORTH AMERICAN SPECIALTY INSURANCE COMPANY**

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADMINISTRATOR ENDORSEMENT

~~Schedule Item 8~~**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended ~~to read~~ as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 8. Administrator is deleted and replaced with the following:

8. **ADMINISTRATOR**:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

MONTHLY AGGREGATE REIMBURSEMENT ENDORSEMENT

~~SECTION FOUR: AGGREGATE EXCESS~~ of THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended ~~to the extent necessary to eliminate any inconsistencies between it and~~as follows:

I. Section One: Definitions is amended by adding Item 25. Monthly Attachment Point as follows:

25. **MONTHLY ATTACHMENT POINT** shall mean the ~~following:~~number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month of the **Policy Period** multiplied by the Factor as stated in Schedule Item 7(c)(2). The **Monthly Attachment Point** is cumulative for each month of the **Policy Period**, meaning that the **Monthly Attachment Point** for each prior month is added together to determine the current **Monthly Attachment Point**.

~~8~~II. Section Four: Aggregate Excess is hereby amended by adding Item 6. Monthly Aggregate Reimbursement as follows:

6. **MONTHLY AGGREGATE REIMBURSEMENT.** Subject to all other provisions of the **Policy**, we will reimburse you for **Loss** during the **Policy Period** in excess of the **Monthly Attachment Point** subject to the following conditions:

~~a~~a. For the first three months of the **Policy Period**, no monthly aggregate reimbursements will be made to you.

b. After the end of the fourth month of the ~~first~~ **Policy Period** ~~that this Endorsement has been in force~~, and at the end of each subsequent month of the **Policy Period**, we will reimburse you the amount of **Loss** which exceeds the cumulative **Monthly Attachment Point**, but only if the **Loss** exceeds the **Monthly Attachment Point** by at least $5,000~~.~~ (USD).

~~b.~~ ~~c~~. The **Loss** will be paid to the **Administrator** within fifteen (15 ~~working~~) business days after the requirements of ~~**SECTION FOUR: AGGREGATE EXCESS** paragraph **5. Notice and paragraph 6.**~~Section Seven: Claims, Item 10, Aggregate Excess Report, Item 11(b) Proof of Loss, Aggregate Excess Claims, and Item 11(c), Proof of Loss, Additional Documentation, have been satisfied by you.

~~c~~d. After the end of the **Policy Period**, if your total **Loss** does not exceed the ~~annual~~**Minimum Attachment Point** ~~calculated under~~, as defined in Schedule Item 7(c)(3), you will reimburse us the total amount of **Loss** paid to you via the monthly aggregate reimbursements within fifteen (15 ~~working~~) business days after you or the **Administrator** receives our ~~request~~demand for reimbursement. Failure to reimburse us within fifteen (15 ~~working~~) business days will result in a two percent (2~~%~~%) per month penalty until such amounts are ~~repaid~~paid in full.

e. After the end of the **Policy Period,** if the total amount of **Loss** paid to you during the **Policy Period** is greater than the total **Loss** due to you under ~~d~~Section Four: Aggregate Excess, Item 2. Aggregate Excess Indemnity for the **Policy Period**, you will reimburse us the difference within fifteen (15) business days after you or the **Administrator** receives our demand for reimbursement. Failure to reimburse us within fifteen (15) business days will result in a two percent (2%) per month penalty until such amounts are paid in full.

f. If the **Policy** terminates prior to the end of the **Policy Period**, then you or the **Administrator** must reimburse us the total amount of **Loss** paid to you within fifteen (15 ~~working~~) business days after the termination date. Failure to reimburse us will result in a two percent (2~~%~~%) per month penalty until such amounts are ~~reimbursed~~paid in full.

~~e. After the end of the **Policy Period,** if the total amount of **Loss** paid to you during the **Policy Period** is greater than the total **Loss** due to you under **SECTION FOUR: AGGREGATE EXCESS** paragraph **2. Indemnity** for the **Policy Period**, you will reimburse us the difference within 15 working days after you or the Administrator receives our request. Failure to reimburse us within 15 working days will result in a 2% per month penalty until such amounts are repaid.~~

~~f. **MONTHLY ATTACHMENT POINT** as used in this Endorsement is calculated as follows: the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month multiplied by the Factor shown in Schedule Item 7(c)(2). The Monthly Attachment Point is cumulative for each month, meaning that the Monthly Attachment Point for each prior month is added together to determine the current Monthly Attachment Point.~~

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATING SPECIFIC RETENTION OPTION ENDORSEMENT

~~With respect to each~~ **THIS ENDORSEMENT CHANGES THE POLICY** ~~**Period**, in~~ **. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. Schedule Item 6. Specific Excess is amended by adding the following:

6. **SPECIFIC EXCESS**:

h. Aggregating Specific Retention. In addition to ~~Schedule Item 6(b)~~retaining the Specific Retention each Person~~,~~ amount for each **Loss Incurred** under this **Policy**, as defined in Schedule Item 6(b), you ~~must~~ also agree to retain the following ~~aggregate retention~~Aggregating Specific Retention amount for all ~~-~~**Persons**~~, to be satisfied using only~~ with a **Loss** under this **Policy**:

Only those amounts of the **Losses** exceeding ~~each~~the Specific Retention each Person~~:~~ will be aggregated to satisfy the Aggregating Specific Retention amount. We will not indemnify you on a specific **Loss** prior to your reaching the above defined Aggregating Specific Retention amount.

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~ **NORTH AMERICAN SPECIALTY INSURANCE COMPANY**

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ATTACHMENT POINT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(c) is ~~amended to read as follows:~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

c~~).~~. Attachment Point:

~~(1)~~ (1) Estimated Attachment Point:

~~(2)~~ (2) Factor:

~~(3)~~ (3) Minimum Attachment Point:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

~~ADD~~ COVERED UNIT(S)
SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As ~~respects accidents taking place and sicknesses diagnosed on or after~~of the effective date of this **Endorsement**, Schedule Items 6(e) and 7(f) are ~~amended as follows~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

e~~).~~. Covered Unit(s):

7~~(~~. **AGGREGATE EXCESS**:

f~~).~~. Covered Unit(s):

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

DELETE PLAN ENDORSEMENT

~~The~~**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, the following **Plan** is deleted from Schedule Item 5:

5. **PLAN NAME**:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE INDEMNITY LIMIT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(e) is ~~amended to read as follows:~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

e~~)~~. Indemnity Limit: ~~_____~~

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted
President

Facsimile signature to be inserted
Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(d) is ~~amended to read as follows:~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

d~~)~~. Indemnity Percentage:~~—~~

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted President

Facsimile signature to be inserted Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(c) is ~~amended to read as follows:~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

c~~).~~. Indemnity Percentage:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

INSURED ENDORSEMENT

~~Schedule Item 1~~**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended ~~to read~~ as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 1. Insured is deleted and replaced with the following:

1. **INSURED**:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(a) is ~~amended to read as follows:~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

a~~)~~. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(a) is ~~amended to read as follows:~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

a~~).~~. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGREGATE LOSS LIMIT PER PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(b) is ~~amended to read as follows~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

b~~).~~ . Loss Limit Per Person:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

NON-MEDICAL BENEFITS COVERED
SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As ~~respects **Loss** as a result of accidents taking place and sicknesses diagnosed on and after~~of the effective date of this **Endorsement**, Schedule ~~Item(s)~~Items 6(f) and 7(g) are ~~amended to read as follows~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

f~~).~~. Non-medical Benefits covered:

7~~(~~. **AGGREGATE EXCESS**:

g~~).~~. Non-medical Benefits covered:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted
President

Facsimile signature to be inserted
Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

PLAN NAME ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As ~~respects accidents taking place and sicknesses diagnosed on or after~~of the effective date of this **Endorsement**, Schedule Item 5~~ is amended to read as follows~~. Plan Name is deleted and replaced with the following:

5. **PLAN NAME**:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

POLICY PERIOD ENDORSEMENT

~~Schedule Item 4~~**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended ~~to read~~ as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 4. Policy Period is deleted and replaced with the following:

4. **POLICY ~~-~~PERIOD**:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE MONTHLY PREMIUM RATE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(h) is ~~amended to read as follows:~~deleted and replaced with the following:

7~~(~~. **AGGREGATE EXCESS**:

h~~).~~. Monthly Premium Rate:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC EXCESS PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(g) is ~~amended to read as follows~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

g~~)~~. Premium:

	Rating Classification	**Monthly Rate**

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC RETENTION EACH PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(b) is ~~amended to read as follows~~deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

b~~)~~. Retention each Person:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

AGGREGATE TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

~~As respects~~**THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY**

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

~~This option applies only if the **Policy** coverage terminates at the end of the **Policy Period** and you purchase fully insured coverage.~~

~~Schedule Items 7(a) and 7(c) are amended to read as follows:~~

Schedule Item 7(a) will be amended to reflect the following liability basis for your Aggregate Excess coverage. Schedule Item 7(c) will be amended to reflect your revised Attachment Point criteria.

SCHEDULE OF INSURANCE

7. **AGGREGATE EXCESS**:

   a. Liability Basis:

      (1) Claims Incurred from _____ through _____

      (2) Claims Paid from _____ through _____

   ~~c.~~ c. Attachment Point:

      (1) Estimated Attachment Point

      (2) Factor:

      (3) Minimum Attachment Point:

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

SPECIFIC TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

~~As respects~~**THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY**

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

~~This option applies only if the **Policy** coverage terminates at the end of the **Policy Period** and you purchase fully insured coverage.~~

Schedule Item 6(a) ~~is~~will be amended to ~~read as follows:~~reflect the following liability basis for your Specific Excess coverage.

SCHEDULE OF INSURANCE

6. **SPECIFIC EXCESS**

   a. Liability Basis:

      (1) Claims Incurred from_____ through _____

      (2) Claims Paid from_____ through _____

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

A Stock Insurance Company
650 Elm Street, 6th Floor ▪ Manchester, NH 03101-2524
(800) 542-9200

EXCESS MEDICAL INDEMNITY POLICY

Insured:

Policy Number:

Effective Date:

State of Delivery:

This **Policy** is a legal contract. In consideration of **Premium** paidpremium **Paid**, North American Specialty Insurance Company agrees to reimburse **Losses** in accordance with the terms of this **Policy**. Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine your rights, duties and what is and is not covered.

Throughout this **Policy** and the **Schedule**, the words "you" and "your" refer to the Insured shown above and in the **Schedule**. The words "we", "us" and "our" refer to North American Specialty Insurance Company. Other words and phrases that appear in capitalbold letters have defined meaning. Refer to the **Policy** and **Schedule** and **Policy** if you have questions on the meaning of these terms.

This **Policy** is issued in, and will be governed by, the laws of the State of Delivery shown above, unless otherwise preempted by federal law. Acceptance of this **Policy** means that the Insured agrees to the terms and conditions of this **Policy**.

This **Policy** is executed by printing the facsimile signatures of our President and Assistant Secretary on the attached signature page and by the actual signature of the authorized representative on the **Schedule**.

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

THE ATTACHED DISCLOSURES, COVERAGE FORM(S) AND OTHER FORMS AND ENDORSEMENTS, IF ANY, FORM THE ATTACHED POLICY.

IN WITNESS WHEREOF, North American Specialty Insurance Company has caused this **Policy** to be executed and attested by our duly authorized representative(s).

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted	*Facsimile signature to be inserted*
President	Secretary

TABLE OF CONTENTS

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

A Stock Insurance Company
650 Elm Street, 6th Floor ▪ Manchester, NH 03101-2524
(800) 542-9200

SCHEDULE OF INSURANCE

THIS IS A CLAIMS PAID POLICY
PLEASE READ CAREFULLY

The following insurance only applies to the **Policy Period** shown in this **Schedule**. A separate **Schedule** will be issued for each succeeding **Policy Period**.

1. **INSURED:**

2. **ADDRESS:**

3. **POLICY NUMBER:**

4. **POLICY PERIOD:**

5. **PLAN NAME:**

6. **SPECIFIC EXCESS:**

~~This Policy ☐ ***does*** ☐ ***does not*** include Specific Excess coverage.~~

a. Liability Basis:

(1) Claims Incurred from: _____ through _____

(2) Claims Paid from: _____ through _____

b. Retention each Person:

c. Indemnity Percentage:

d. ~~Lifetime~~Policy Period Limit:

e. Covered Unit(s):

f. Non-medical Benefits covered:

g. Premium:

Rating Classification	**Monthly Rate**

7. **AGGREGATE EXCESS:**

This **Policy** ☐ ~~***does***~~***includes*** ☐ ~~***does not*** include~~***excludes*** Aggregate Excess Coverage. (If neither or both boxes are marked, then the assumption is that Aggregate Excess Coverage is excluded under this **Policy**.)

a. Liability Basis:

(1) Claims Incurred from~~_____~~: _____ through _____

(2) Claims Paid from~~_____~~: _____ through _____

b. Loss Limit Per Person:

~~c.~~ c. Attachment Point:

(1) Estimated Attachment Point:

(2) Factor:

(3) Minimum Attachment Point:

d. Indemnity Percentage:

e. Indemnity Limit:

f. Covered Unit(s):

g. Non-medical Benefits covered:

h. Monthly Premium Rate:

8. **ADMINISTRATOR:**

9. **ENROLLMENT:** Total Covered Employees:

10. **MINIMUM NUMBER OF COVERED LIVES:**

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

~~Countersignature~~

_____ _____

~~Licensed Resident Agent~~ ~~Date~~

Authorized North American Specialty Representative Date

SECTION ONE: DEFINITIONS

1. ~~**ADMINISTRATOR**~~ **ADMINISTRATOR** means the organization ~~named in Schedule Item 8 and which~~ contracted by you ~~selected~~ to ~~pay **Benefits** under~~ adjudicate all claims arising from the **Plan**. ~~The **Administrator** is your contractual agent and does not represent us in any way. Unless you get written consent from us, termination~~act of ~~the contract between you and the **Administrator** named in Schedule Item 8 will automatically cancel this **Policy** as of the date that your contract with the **Administrator** terminates. You agree to:~~

   ~~a. contract with the **Administrator** for~~ adjudication shall include but not be limited to the investigation, payment, denial ~~or~~and settlement of ~~all claims for **Benefits** under the **Plan**;~~

   ~~b. hire counsel to defend all litigation arising out of denied claims, but we have the right to participate and control in the defense of any claim which might result in a **Loss** to us;~~

   ~~c. pay all fees charged by the **Administrator** for its services;~~

   ~~d. provide the **Administrator** with sufficient funds to pay all claims for **Benefits** under the **Plan** as they become due; and~~

~~e. require the **Administrator** to pursue and take advantage of all discounts and other cost reducing procedures in paying~~ claims for **Benefits** under the **Plan**. The **Administrator** ~~must immediately notify us in writing if no discounts or other managed care opportunities are otherwise available with respect to any **Losses** under the **Plan**.~~ is designated in Schedule Item 8.

~~2.~~ 2. **ALTERNATIVE CARE** means a **Treatment**, identified through a case management provider, which substitutes a covered expense under your **Plan** for another covered expense under your **Plan**. Guidelines regarding the eligible expenses of **Alternative Care Treatment** under this **Policy** are set forth within Section Seven: Claims, Item 6.

3. **BENEFITS** means any medical ~~and prescription drug coverages~~coverage(s) provided by the **Plan**, and any non-medical coverage(s~~)~~), provided ~~in~~by the **Plan** ~~and described~~, specifically listed in Schedule Items 6(f) or 7(g). Dental, vision, hearing, prescription drugs, prescription drug card, retail prescription drugs, and weekly income **Benefits** are examples of non-medical coverages. ~~Any prescription drug card program(s) do~~Non-medical coverages not ~~constitute **Loss** unless described~~listed in the **Schedule** ~~Items 6(f) or 7(g).~~ are not covered by this **Policy**.

~~3.~~ ~~**CASE MANAGEMENT FEES** means~~4. **CASE MANAGEMENT FEES** are fees **Paid** ~~for case management for a covered **Person**. Coverage of **Case Management Fees** is limited to fees **Paid** to a certified~~to an independent third party case management provider ~~(other than an employee or affiliated company of the **Administrator**)~~ for the coordination and management of ~~healthcare~~health care delivery to a **Person** covered under the **Plan** through appropriate ~~referral~~referrals to ~~a~~ qualified and approved medical ~~provider. **Case Management Fees** do not include fees **Paid** on a capitated basis (e.g., per **Employee** per month) by you or the **Administrator**. **Case Management Fees** are in addition to **Benefits** under the **Plan**~~providers.

~~4~~5. **COVERED UNIT** means a particular class of **Employees** (and the eligible covered dependents of the **Employees** under the **Plan**) who are covered under the **Plan** and ~~-~~indemnified by this **Policy** and identified under Schedule Items 6(e) or 7(f). A **Covered Unit** may be identified by company name, division, location or group.

~~5~~6. **EMPLOYEE** means any individual who is employed by you in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired **Employees** or the dependents of retired **Employees** unless ~~otherwise agreed to by us.~~specifically identified for coverage under this **Policy** as listed in Schedule Items 6(e) and/or 7 (f).

~~6~~7. **ENDORSEMENT**~~.~~ means a written alteration or amendment to the terms of this **Policy** issued by us and which is made a part of this **Policy**.

~~7~~8. **EXPERIMENTAL AND/OR INVESTIGATIONAL** means a **Treatment** which does not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the United States of America medical community or the U.S. federal government oversight agencies at the time services were rendered.

9. **INCURRED** means the date on which services for covered **Benefits** for a covered **Person** are performed by a qualified medical provider.

~~8.~~ 10. **INDEPENDENT MEDICAL REVIEW** means the analysis of the **Treatment** by a clinical reviewer of a URAC (formerly known as the Utilization Review Accreditation Commission) accredited independent review organization, who is a board certified physician in the same medical specialty or subspecialty of the underlying **Loss**~~.~~, and both external and independent to the **Plan** and the **Administrator**.

11. **LOSS** or **LOSSES** means the amount **Paid** for claims by you or ~~**Paid by**~~ the **Administrator** for **Benefits** under the **Plan**. **Loss** includes the amount **Paid** by you or ~~**Paid by**~~ the **Administrator** in settlement of claims ~~for **Benefits** under the **Plan** and the amount **Paid** by you or **Paid** by the **Administrator**~~or in satisfaction of judgments for **Benefits** under the **Plan**. **Loss** also includes **Case Management Fees Paid** by you or the **Administrator** when claims exceed the Retention amount shown in Schedule Item 6(b).

~~9. **PAID**~~ 12. **MATERIAL** or **MATERIAL CHANGE** means a change or combination of changes in the risk assumed by us, as solely determined by us. **Material** or **Material Change** includes but is not limited to the following:

a. a change, modification, or revision to the **Plan** that we determine would increase our risk under this **Policy**;

b. a change or increase in liability due to the acquisition of, merger with, or sale of the Insured to another company or employer;

c. a change in your management, **Administrator's** management, or PPO contracts; or

d. a change in the majority ownership of the Insured.

13. **MEDICALLY NECESSARY** means a **Treatment** that is prescribed by a physician or licensed medical practitioner, who is acting within the scope of his or her license, and meets all of the following elements:

a. Is appropriate for the diagnosis and **Treatment** of an illness, injury, or pregnancy in accordance with generally accepted medical practice and professional standards;

b. Is the most appropriate treatment, supply, device, or level of service to provide safe and adequate care; and

c. Is not **Experimental and/or Investigational**, Cosmetic, Custodial in Nature, or Unproven.

Cosmetic means a **Treatment** or portion of a **Treatment** with the purpose of improving appearance rather than curative or restoration of general health. Noted exceptions to this definition are repairs of congenital cleft palates and breast reconstruction after mastectomy.

Custodial in Nature is care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care. Activities of daily living are defined as assistance in walking, getting in and out

of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.

Unproven is the lack of scientific evidence or outcome studies to demonstrate the medical effectiveness of the proposed medical **Treatment**.

14. **PAID** means that a claim has been adjudicated by the **Administrator** and funds have actually been disbursed by the **Plan** or **Administrator** as unconditional and direct payment to the applicable **Person** or health care provider(s) during the **Claims Paid** period as defined in Schedule Item 6(a)(2) and/or Schedule Item 7(a)(2), if applicable.

Payment will be deemed made on the date ~~shown on each check,~~that both:

a. the **Plan** or **Administrator** directly tenders payment by mailing, transmitting or other delivery of a draft, check or wire ~~or~~ transfer ~~of~~; and

b. the account upon which the payment is drawn contains and continues to contain sufficient funds ~~(which clears~~to permit the draft, check or wire transfer to be honored by the financial institution~~)~~ ~~issued by you or the **Administrator** in payment of an **Incurred** claim, but only if the check or draft is dated, mailed or otherwise delivered during the same **Policy Period**~~ upon which it is drawn.

~~10~~15. **PERSON** means any **Employee** included in a **Covered Unit**, and the eligible covered dependents of the **Employee**, who are enrolled and covered for **Benefits** under the **Plan**.

~~11~~16. **PLAN** means the self-insured ~~**Employee**~~employee benefit ~~**Plan**~~plan named in Schedule Item 5 and recorded within a **Plan Document**. You agree to furnish us a copy of the **Plan Document** within ~~-~~ninety (90) days after the beginning of the **Policy Period**. A copy of ~~this~~the **Plan Document** is attached and made a part of this **Policy** as Exhibit A.

~~12~~17. **PLAN CHANGE** means any alteration or amendment to the **Plan**, but unless each change is sent to us and accepted in writing by us, this **Policy** will apply as if the change had not been made. ~~We have the right to revise any Schedule Item(s) as of the effective date we accept the **Plan Change**.~~ You agree to furnish a copy of any **Plan Change** to us at least thirty (30) days before it becomes effective.

~~13~~

18. **PLAN DOCUMENT** means the complete written **Plan** and/or trust which govern the operation and administration of the **Plan**, including eligibility, coverage, claim procedures and payment of **Benefits**. The **Plan Document** is not the descriptive booklet given to covered **Persons**, or the summary plan description. The **Plan Document** includes all written instruments governing the **Plan** including any amendments(s) accepted by us pursuant to this **Policy**.

19. **POLICY** means this Excess Medical Indemnity Policy, and the **Schedule**, Exhibits, and ~~the~~ **Endorsements** (if any). The **Policy** is a contract of insurance between you (the Insured shown in Schedule Item 1) and us (the Insurer named on the face page of this **Policy**). The terms and conditions of this **Policy** may not be altered or waived except by **Endorsement** issued by us.

~~14~~20. **POLICY PERIOD** ~~-~~means the period of time shown in Schedule Item 4 and any succeeding **Schedules**. ~~If~~

21. **PROOF OF LOSS** means the documentation of claims **Incurred** under the **Plan** and submitted for reimbursement under this **Policy** ~~is cancelled before the **Policy Period** expires, the **Policy Period** will end on the cancellation date.~~ . Documentation must be to our satisfaction. The standards of Proof of Loss for each type of claim are further set forth in Section Seven: Claims, Item 11.

~~15~~22. **SCHEDULE**~~-~~ means the pages of this **Policy** which show your name, the name of the **Plan** and other terms of insurance included in the Schedule of Insurance.~~-~~ A separate **Schedule** will be issued for each succeeding **Policy Period**.

23. **TREATMENT** means any medical procedure, service, device, supply, drug, care or treatment provided to a **Person** by a physician or medical provider.

24. **USUAL, REASONABLE AND CUSTOMARY** means the standard charges assessed by a group, entity, or individual for physician or medical provider services, hospital supplies, hospital bed rates, drugs, ancillary services, or durable medical equipment, to the extent that such charges do not exceed the general level of charges made by other physicians or medical providers who render similar **Treatments** to similarly ill or injured persons in the same geographical area.

SECTION TWO: PREMIUM

1. **CALCULATION**. Each month's ~~**Premium**~~premium due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the ~~1st~~first day of each month during the **Policy Period**.

2. **DUE DATE**. Premium is due to us on the first day of each month during the **Policy Period**. Each ~~**Premium**~~premium payment must be accompanied by a report showing the number of **Employees**, as of the first day of the month, who are part of each Rating Classification shown in Schedule Items 6(g) and 7(h).

3. **GRACE PERIOD**. A Grace Period of thirty-one (31) days following the premium due date will be granted for the payment of each month's premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period. ~~A Grace Period of 31 days following the **Premium** due date will be granted for the payment of each monthly **Premium**.~~

4. **NON-PAYMENT**. ~~—~~Failure to pay in full any month's ~~**Premium**~~premium within ~~31 days after~~ the ~~**Premium due date**~~Grace Period will cancel the **Policy** as of the ~~**Premium**~~premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full monthly premium is not paid prior to the expiration of the Grace Period.

5. **REINSTATEMENT**. If any ~~**Premium**~~premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate ~~-~~the **Policy** on the terms and conditions that we ~~may~~ elect at that time.

6. ~~**ADJUSTMENTS**~~**ADJUSTMENTS**. If you pay any ~~**Premium**~~premium in excess of the amounts due to us, ~~we will adjust these amounts~~you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next premium payment due to us. A request for refund or a claim of offset for a future premium payment must be given to us in writing, stating the basis and ~~return the **Premium** back to you. Any **Premium** to be returned to you pertaining to any **Policy Period**~~calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the premium payment amount was adjusted. No premium adjustments will be ~~waived~~allowed after ~~one year~~ninety (90) days following the ~~end~~conclusion of the **Policy Period** ~~unless you notify us in writing prior to this date. We are entitled to offset any reimbursements~~.

7. **MINIMUM MONTHLY PREMIUM PAYMENTS**. Monthly payments of premium due ~~you for **Losses Paid** for **Plan Benefits**~~ under this **Policy** ~~against **Premiums** or other amounts due us.~~will not be less than the minimum monthly premium payment. The minimum monthly premium payment is calculated by multiplying the Minimum Number of Covered Lives, as defined in Schedule Item 10, by the per **Person** premium rates for Specific Excess coverage, as defined in Schedule Item 6(g) and if applicable, for Aggregate Excess coverage, Schedule Item 7(h).

SECTION THREE: SPECIFIC EXCESS

1. **RETENTION EACH PERSON**. You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** shown in Schedule Item 6(b) which is **Incurred** during the dates shown in Schedule Item 6(a)(1) and **Paid** by you or ~~**Paid** by~~ the **Administrator** for **Benefits** under the **Plan** for each **Person** during the dates shown in Schedule Item 6(a)(2).

2. **INDEMNITY**.~~—~~ We will indemnify and reimburse you the percentage shown in Schedule Item 6(c) of the amount of **Loss Paid** by you or the **Administrator** during the **Policy Period** that exceeds the Retention. We will not ~~-~~reimburse you more frequently than one (1) time each month for each **Person** under this **Policy**.

3. ~~**LIFETIME**~~**POLICY PERIOD LIMIT**. ~~Regardless of the number of succeeding **Policy Periods**, the~~The amount shown in Schedule Item 6(d) is the ~~Limit~~limit of the **Loss** for which we will reimburse you with respect to each **Person** during the ~~lifetime of the~~**Policy Period**. The Policy~~. This Lifetime~~ Period Limit ~~will be decreased by~~includes the ~~sum~~amount of ~~the Retentions for each~~Retention Each Person for each **Policy Period** ~~in which we indemnify a **Loss**. This Lifetime Limit also will be decreased by all specific **Loss** pertaining to each **Person** under any and all previous Specific Excess indemnity policies we may have issued to you. Any increase in the Lifetime Limit shown in Schedule Item 6(d), which we will amend by **Endorsement**, does not apply to any **Loss** resulting from any accident taking place or sickness diagnosed prior to the Effective Date of the **Endorsement**~~.

4. **NOTICE.** You or the **Administrator** will give us written notice (in a form satisfactory to us) within 30 days after **Losses Paid** for any covered **Person** exceeds 50% of the Retention (or may exceed the Retention due to the condition) shown in Schedule Item 6(b), or when any covered **Person** has been diagnosed with a condition that has been identified in an **Endorsement** to this **Policy**. You or the **Administrator** will give us written notice of any lawsuit, threatened lawsuit or other formal proceeding against the **Plan** which might result in a **Loss** to us.

5. **LATE REPORTING.** If we do not receive written Notice within 90 days after **Losses Paid** by you or the **Administrator** exceeds the Specific Excess Retention, we will reduce our reimbursements under the **Policy** as follows:

Time	Reduction
91 - 120 Days	15%
121 - 180 Days	30%
181 - 365 Days	50%

6. **PROOF OF LOSS** means we will reimburse you for **Loss** covered by this **Policy** after we receive satisfactory proof that you or the **Administrator** has **Paid** the **Loss**. Satisfactory proof includes, but is not limited to:

a. our completed loss advice form;
b. proof of eligibility under the **Plan**;
c. claim payment report, including provider of services, **Incurred** from and to dates, **Paid** amount, **Paid** dates, and check numbers;
d. itemized medical bills (as applicable);
e. attending physician statements and medical narratives;
f. the date the accident occurred or the date the sickness was diagnosed; and
g. the date that medical care was first received.

If we ask for **Loss** documentation that is not described above, you agree to require the **Administrator** to provide it to us. It is your responsibility and financial obligation to provide us with satisfactory **Proof of Loss**.

SECTION FOUR: AGGREGATE EXCESS

1. **ATTACHMENT POINT.**ATTACHMENT POINT. You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** equal to the Attachment Point indicated, as defined in Schedule Item 7(c)), which is **Incurred** during the dates shown in Schedule Item 7(a)(1) and **Paid** by you or **Paid** by the **Administrator** during the dates shown in Schedule Item 7(a)(2). The Estimated Attachment Point indicated in Schedule Item 7(c)(1) is a calculation based on the number of **Employees** at the beginning of the **Policy Period**. The Attachment Point is the sum of the amounts

The Attachment Point is calculated for each **Policy Period**, as follows: the sum of the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of theeach month during the **Policy Period** multiplied by the Attachment Point Factor shown in Schedule Item 7(c)(2). The calculated Attachment Point will not be less than the Minimum Attachment Point amount shown in Schedule Item 7(c)(3).

The Estimated Attachment Point, as stated in Schedule Item 7(c)(1), is a calculation based upon the total number of covered **Employees** at the beginning of the **Policy Period**, as stated in Schedule Item 9, multiplied

by the total number of months within the **Policy Period**, times the Attachment Point Factor, as stated in Schedule Item 7(c)(2. ~~**INDEMNITY**~~). The Estimated Attachment Point is only a reference point for the anticipated aggregate excess retention amount upon binding of this **Policy**. However, for purposes of determining the actual Aggregate Excess retention amount, the above stated Attachment Point calculation will be utilized.

2. **INDEMNITY**. We will ~~-~~reimburse you an amount equal to the Indemnity Percentage as shown in Schedule Item 7(d) ~~of~~ multiplied by the difference between the total **Loss** ~~exceeding~~minus the calculated Attachment Point. In calculating the ~~Attachment Point and our Indemnity,~~total **Loss** for the applicable **Policy Period**, we will utilize a **Loss Limit Per Person** ~~is limited to the amount shown in Schedule Item 7(b).~~amount.

3. ~~**LOSS LIMIT PER PERSON** means, when~~**LOSS LIMIT PER PERSON**. When calculating our ~~Indemnity~~Aggregate Excess indemnity obligation to you, **Loss~~(es)~~** pertaining to each **Person** during each **Policy Period** will be limited to the amount shown in Schedule Item 7(b).

4. ~~**INDEMNITY LIMIT.**~~ **AGGREGATE EXCESS INDEMNITY LIMIT**. Our Aggregate Excess Indemnity for each **Policy Period** will not exceed the Indemnity Limit shown in Schedule Item 7(e).

~~5. **NOTICE**. You will require the **Administrator** to send us written notice (in a form satisfactory to us) within 20 days after the end of each calendar month during the **Policy Period** showing: (a) the number of **Employees** in each **Covered Unit** who are covered by the **Plan** on the first day of the month; and (b) the total amount of **Losses** for all covered **Persons Paid** by you or **Paid** by the **Administrator** during the prior month. These reported **Losses** must be within the **Loss Limit Per Person** shown in Schedule Item 7(b). This report will identify and segregate **Losses** by each **Covered Unit**.~~

~~6. **PROOF OF LOSS**. After the end of the **Policy Period** we will reimburse you for **Loss** covered by this **Policy** after we receive satisfactory **Proof of Loss** you or the **Administrator** has **Paid** the **Loss**. You or the **Administrator** must provide us with this satisfactory proof within 90 days after the end of the period designated in Schedule Item 7(a)(2) in order for us to consider reimbursing this Aggregate Excess claim. Satisfactory **Proof of Loss** includes, but is not limited to:~~

~~a. our completed loss advice form;~~
~~b. computer reports of total **Paid** claims (month by month) during the **Policy Period** showing claimant, **Incurred** date, **Paid** date, provider and amount **PAID**;~~
~~c. computer reports showing total **Employee** census information (month by month) during the **Policy Period**; and~~
~~d. documentation showing any voided payments, refunds, or other adjustments.~~

~~If we ask for **Loss** documentation that is not described above, you agree to require the **Administrator** to provide it to us. It is your responsibility and financial obligation to provide us with the requested satisfactory **Proof of Loss**.~~

~~7. **CANCELLATION.**~~5. **CANCELLATION**. If you cancel this **Policy** before the **Policy Period** expires, no amounts will be reimbursed by us for Aggregate Excess **Losses** under this **Policy**.

SECTION FIVE: AMENDMENTS

1. **WE HAVE THE RIGHT TO AMEND ANY SCHEDULE ITEMS ON THE DATE THAT**:

a. we accept a **Material Plan Change**;

b. a **Covered Unit** is added or deleted;

c. the **Policy Period** expires;

d. you request a change in **Policy** terms;

e. a state or federal law **materially** alters your obligation under the **Plan**;

f. the total number of **Employees** in all **Covered Units** increases or decreases by more than:

(1) 25%i. Fifteen Percent (15%) during any single month of the **Policy Period**; or

(2) 10% duringii. Twenty-Five Percent (25%) for any three (3) consecutive months of the **Policy Period**. combined;

gg. the total number of **Employees** in all **Covered Units** as reported for the first day of the **Policy Period** is fifteen percent (15%) higher or lower than the total number of **Employees** represented by you at binding of coverage of this **Policy** and documented as the Total Covered Employees within Schedule Item 9;

h. the average monthly claims **Paid** by you or the **Administrator** during the last two (2) months of the previous **Policy Period** exceeds (by more than ten percent (10%) the average monthly claims **Paid** during all other months of the previous **Policy Period**.;

hi. a material change**Material Change** in the makeup of the **Employees** of the Insured due to merger or acquisition, unless we have agreed in writing to such change.;

ij. you or the **Administrator** provided us with incomplete or inaccurate census and/or claim information, inaccurate **Employee** or dependent qualification or classification, or any other mistake or misrepresentation, with respect to any material**Material** term of this **Policy**.; or

k. you or the **Administrator** change PPO networks.

SECTION SIX: EXCLUSIONS

1. **THIS POLICY DOES NOT APPLY:**

a. to **Loss Paid** by you or the **Administrator** and reported to us more than one (1) year after the end of the **Policy Period** in which the **Loss** is **Paid**;

b. to ~~claim~~ expenses, payments or expenditures for any non-medical expenses incurred as a result of the administration of the **Plan**, including but not limited to~~: administrative fees, salaries paid to your **Employees**,~~ the following:

i. claims administration, investigation ~~expenses, attorney~~fees, attorneys fees ~~and~~, court ~~costs;~~

~~e. to~~cost, and fees ~~paid to the~~ for obtaining medical records billed by the **Administrator** ~~for non-claim services or~~ (including fees ~~paid to any actuary, accountant, consultant~~generated from companies owned in whole or in part by the **Administrator,** companies with a corporate or other legal affiliation or joint ownership with the **Administrator**, or by a spouse, child or immediate family member of the **Administrator**, unless we grant prior written authorization. Failure to provide prior disclosure of such an ownership or relationship interest will exclude all indemnifiable **Loss** under this **Policy** attributed to such fees);

ii. compensation paid to officers, employees, consultants, brokers, actuaries, accountants, independent contractors, or any other person or entity performing non-claim services for the **Plan**; and

~~d~~iii. any surcharges, assessments, or taxes imposed by any federal, state or local government entity, hospital or agency upon self-insurers;

c. to any **Material Plan Change** which we have not accepted in writing;

~~e~~d. to **Benefits Paid** by you in ~~any~~ one **Policy Period** but allocated to another **Policy Period**. No reimbursement will be made under both the Aggregate and Specific Excess provisions of this **Policy** if, by so doing, we would in any way make reimbursement more than once for any **Loss**;

~~f~~e. to administrative fees related to a prescription drug card program, unless otherwise agreed to by us in writing;

~~g. to medical care involving experimental or investigational surgery or treatment which is considered experimental by the American Medical Association, the Food and Drug Administration or the Health Care Financing Administration of the Department of Health and Human Services, unless otherwise required by applicable law;~~

~~h. to Medicare **Benefits**~~f. to **Experimental and/or Investigational Treatments**;

g. to any **Treatment** that is not **Medically Necessary**;

h. to the cost resulting from a **Loss** that is in excess of the **Usual, Reasonable and Customary** charges;

i. to non-skilled custodial or residential services. Services are deemed to be non-skilled custodial or residential services if the services i) do not require the skill of a licensed Registered Nurse, ii) are not curative and/or restorative in nature, and iii) are primarily intended to assist in the activities of daily living as defined by Medicare (e.g. bathing, dressing, feeding, toileting, transferring);

j. to expenses for **Benefits** for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, and for which the **Person** would be entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, regulation or policy, whether or not such policy is actually in force;

k. to expenses incurred while a **Person** is engaged in an act that is illegal under federal or state law, or as a result of their illegal act. Illegal acts include but are not limited to participation in a riot or other act of civil disobedience; operation of a motorized vehicle (including but not limited to automobile, motorcycle, ATV, boat, personal watercraft and snowmobiles) while intoxicated, as defined by the applicable state law, due to drugs, alcohol, or narcotics; voluntary consumption or use of a controlled substance that has not been legally prescribed by a treating medical provider; or any other charged felony or misdemeanor;

l to expenses incurred resulting from a war, declared or undeclared, hostilities, invasions, insurrections, or civil war;

m. to expenses incurred by a **Person** resulting from a hazardous hobby or activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm or injury. Examples of hazardous hobbies or activities shall include, but not be limited to: skydiving; racing of an automobile, ATV, boat, personal watercraft or motorcycle; hang gliding; and bungee jumping;

n. to expenses incurred by a **Person** while detained or incarcerated in a federal, state, or local jail, penitentiary, correctional facility or correctional hospital;

o. to expenses incurred by a **Person** for cosmetic purposes, unless:

i. performed to correct functional disorders or congenital anomalies; or

ii. performed for breast reconstruction of the affected tissue incident to a mastectomy (Women's Health and Cancer Rights Act of 1998); or

iii. due to accidental injury occurring while the individual is a covered **Person**;

p. to Medicare benefits, presuming that, when applying this exclusion, each **Person** eligible for coverage under Medicare became covered for ~~all~~any parts of Medicare on the earliest possible date entitled, and thereafter continuously maintained the Medicare coverage in force. If it is determined that **Benefits** were provided to a **Person** who was eligible for coverage under Medicare but he or she either i) failed to apply for such Medicare coverage or ii) failed to maintain Medicare coverage in force, then said **Benefits** will also be excluded;

~~i.~~ to~~q.~~ for any ~~governmental or regulatory assessments or taxes imposed upon self-insurers, unless otherwise agreed~~portion of an expense which you are not obligated to pay under the terms of the **Plan**, or which is reimbursable to you under:

i. another group health benefit plan; or

ii. a government or privately supported medical research program; or

iii. any coordination of benefits or non-duplication of benefit provisions of your **Plan**; or

iv. any other source;

r. to any billing errors, duplicate bills or duplicate bill items;

s. any amount **Paid** by you or the **Administrator** in excess of a negotiated provider discount, or any penalty or late charge incurred, or discount lost, unless said excess amount, penalty, or late charge has been previously approved by us in writing;

~~j. to any **Benefits** with respect to an alternate treatment program that are not paid in accordance with the plan. However, this exclusion will not apply with respect to any expenses **Incurred** pursuant to an individual treatment plan for which we have given our specific written consent;~~

~~k~~t. to expenses for **Treatment** authorized or approved under any provision of the **Plan** which:

i. allows the **Administrator** to approve an **Alternative Care Treatment** without prior approval from us; or

ii. allows the **Administrator** to alter, modify, or waive a **Plan** provision, standard, or limitation; or

iii. grants you or the **Administrator** discretion to approve coverage for a **Treatment** not otherwise covered under the **Plan**.

However, if the **Treatment** satisfies the requirements set forth within Section Seven: Claims, Item 5, then such expenses will not be deemed excluded.

u. to expenses for **Treatment** rendered to a **Person** by a family member or relative of the **Person**;

v. to payment of medical expenses in excess of **Plan** limits or terms;

w. to payment of medical expense not covered under the terms of the **Plan**. **Administrator's** use of discretionary authority under the **Plan** does not obligate us to recognize and/or reimburse you under this **Policy** for benefits excluded, limited or not listed within the terms of the current **Plan**; and

x. to any of the following legal obligations:

~~(1)~~ i. any liability arising out of the Employee Retirement Income Security Act of 1974~~,~~ (ERISA), as amended, or out of any similar federal or state law or regulation;

~~(2) punitive, exemplary or compensatory damages; or~~

~~(3)~~ ii. any payment for litigation cost and expenses, extra-contractual damages, compensatory damages, punitive or exemplary damages or liabilities, including but not limited to those resulting from negligence, intentional wrong doings, fraud, bad faith or strict liability on the part of the **Insured**, **Plan**, **Administrator** or any agent or representative of the **Insured**, **Plan**, or **Administrator**; or

iii. any other fines or penalties imposed upon the **Insured**, **Plan** or **Administrator** by law or regulation, not already addressed herein.

SECTION SEVEN: ~~RENEWAL AND CANCELLATION~~CLAIMS

~~1. **RENEWAL**. We may offer to renew this **Policy** with you on~~ 1. **ELIGIBLE EXPENSES**. Eligible expenses for a claim against this **Policy** comprise of amounts **Paid** by you for **Medically Necessary Treatments Incurred** by a covered **Person** which:

a. Have been **Paid** in accordance with the terms and conditions of your **Plan**; and

b. Were **Incurred** and **Paid** during the Liability Basis shown in Schedule Item 6(a) or 7(a); and

c. Are **Paid** under a **Benefit** covered by this **Policy**; and

d. Are not otherwise excluded under this **Policy** (Section Six: Exclusions).

2. **YOUR ADMINISTRATOR**.

a. **Administrator** is your contractual agent and does not represent us in any way.

b. You are solely responsible for all fees charged by the **Administrator** for its services rendered to you.

c. **Administrator** may be authorized by you to satisfy the obligations and duties assigned to you under this **Policy**; however the **Administrator's** failure to act or its error in acting will not excuse you from your obligations and duties arising under this **Policy**.

d. **Administrator** will hire counsel to defend all litigation arising out of a denied claim. We reserve the right to participate and control in the defense of any claim which may result in a **Loss** to us.

e. You will provide the **Administrator** with sufficient funds to pay all claims for **Benefits** under the **Plan** as they become due.

f. **Administrator** will pursue and take advantage of all discounts and other cost reducing procedures prior to paying a claim for **Benefits** under the **Plan**. We will not be held accountable for any lost discounts. If **Administrator** is unable to obtain any discount, or only able to obtain a nominal discount (ten percent (10%) or less), or unable to implement managed care opportunities with respect to any **Loss** under the **Plan**, you will notify us immediately. We reserve the right to independently investigate, negotiate and/or pursue any discounts or cost mitigation services available on all **Losses** under the **Plan**. **Administrator** will recognize and honor any discounts or other managed care opportunities identified by us.

g. If you plan to terminate or replace your **Administrator** during the **Policy Period**, you must notify us immediately.

3. **CASE MANAGEMENT PROVIDERS AND EXPENSES**.

a. The case management provider must be either:

i. Approved by us in writing, or

ii. Have current and on-going accreditation by one of the following national organizations: URAC (formerly known as the Utilization Review Accreditation Commission), Commission for Case Manager Certification or the Case Management Society of America.

b. Case management services provided by an employee or affiliated company of the **Administrator** are not eligible for indemnification under this **Policy** unless we give prior written approval.

c. If you or the **Administrator** do not utilize a case management provider, we reserve the right to retain and utilize the services of a case management provider at our own cost and expense.

d. **Case Management Fees** do not include fees **Paid** on a capitated basis (e.g. per **Employee** per month) by you or the **Administrator**.

e. **Case Management Fees** are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.

4. **COST CONTAINMENT FEES**. Fees or charges **Incurred** and **Paid** by you or the **Administrator** for the direct purpose of cost containment for the **Plan** are eligible as a **Loss** under this **Policy** if prior written approval for such fees or charges have been obtained from us. Examples of cost containment fees or charges include but are not limited to the following: negotiation fees, medical cost repricing fees, provider bill audits, network access fees, etc. Cost Containment Fees are subject to the following additional terms:

a. Our acceptance of a cost containment fee or charge will be subject to a demonstration that the work that ~~are in~~ generated the fees or charges resulted in a cost savings to the **Plan**.

b. Cost containment fees are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.

c. Eligible cost containment fees or charges are only reimbursed for claims in which the total **Loss** exceeds the Retention amount shown in Schedule Item 6(b).

5. **COVERAGE GUIDELINES FOR EXPERIMENTAL AND/OR INVESTIGATIONAL, MEDICALLY NECESSARY, AND USUAL, REASONABLE AND CUSTOMARY MEDICAL TREATMENTS AND EXPENSES.**

a. The **Administrator** will be guided by the following standards in making its determination of whether a **Treatment** is **Experimental and/or Investigational**:

i. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time of the drug or device is furnished; or

ii. If "Documented Medical Evidence" shows that the **Treatment** is the subject of on-going Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis; or

iii. If "Documented Medical Evidence" shows that the prevailing opinion among experts regarding the **Treatment** is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis.

"Documented Medical Evidence" shall mean published reports and articles within authoritative medical and scientific literature, or other publication, written or electronic, by a nationally recognized medical specialty group, in regard to a protocol or **Treatment**.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the U.S. Food and Drug Administration for general use.

Treatment for a specific form of cancer that has not completed U.S. Food and Drug Administration Phase III clinical trials, but is considered to be the current standard of care, may be referred to us for review and determination of exemption from a classification of **Experimental and/or Investigational**.

b. The circumstances under which a physician or licensed medical practitioner has prescribed, ordered, recommended or approved any **Treatment** are not conclusive as to whether such **Treatment** is **Medically Necessary** within the scope of this **Policy**.

c. The **Administrator** will make all initial determinations of **Experimental and/or Investigational** and **Medically Necessary** under the **Plan** and provide **Proof of Loss** documentation supporting its determination based upon the standards defined above. We reserve the right to investigate and make any final determination of what is **Experimental and/or Investigational** or **Medically Necessary** and eligible for indemnification under this **Policy** prior to reimbursement.

d. **Usual, Reasonable and Customary ("URC")** charges are determined by the **Administrator** utilizing national and regional industry data, Medicare data, or other similar sources of medical cost data. The **URC** charges shall be based upon the:

i. complexity of the **Treatment**;

ii. the skill of the medical provider or physician;

iii. the intensity of medical service utilized; and

iv. the geographical standards for service and pricing.

We reserve the right to perform bill audit prior to payment of the provider by the **Administrator** and prior to reimbursement, if any, under this **Policy**. We will reimburse the lesser of eligible **URC**, billed charges, or the negotiated rate.

6. **ALTERNATIVE CARE**. **Treatments** of **Alternative Care** may be deemed eligible expenses under this **Policy** when all of the following criteria have been satisfied and evidence thereof has been remitted to us for approval:

a. You demonstrate to our satisfaction that providing the **Alternative Care** resulted in a cost savings to the **Plan**;

b. The **Alternative Care** was recommended by case management provider servicing your **Plan**;

c. The **Alternative Care** was **Medically Necessary**;

d. The **Alternative Care** replaces a **Treatment** that would be covered under your **Plan**;

e. The **Alternative Care** expenses do not exceed the maximum allowed under your **Plan** for the **Treatment** replaced by the **Alternative Care**; and

f. The **Alternative Care** was provided with the consent of the **Person**, or his or her legal representative.

If the **Alternative Care** is provided in lieu of inpatient hospitalization, the **Person** must meet utilization review criteria satisfactory to us for inpatient hospitalization for the entire period the **Alternative Care** is provided. In no event will **Alternative Care** that exceeds ninety (90) days be considered an eligible expense unless approved in writing by us.

7. **FIFTY PERCENT RETENTION AND MAJOR DIAGNOSIS NOTICE REQUIREMENTS**. You or the **Administrator** will give us written notice (in a form satisfactory to us) within thirty (30) days after a **Loss** for any covered **Person** exceeds fifty percent (50%) of the Retention shown in Schedule Item 6(b), or when any covered **Person** has been diagnosed with a medical condition that has been identified in the Major Diagnosis **Endorsement** attached to this **Policy**.

8. **LITIGATION OR OTHER LEGAL EXPOSURES**. You or the **Administrator** will give us written notice, within ten (10) days, of any lawsuit, threatened lawsuit, or other formal proceeding against the **Plan** which may result in a **Loss** under this **Policy**.

9. **LATE REPORTING PENALTY**. If we do not receive a request for reimbursement within one hundred twenty (120) days after a **Loss**, exceeding the Specific Retention, is **Paid** by you or the **Administrator**, we will reduce our indemnity due under this **Policy** by twenty-five percent (25%). Proof of prejudice is not required in our utilization and enforcement of this late reporting penalty.

10. **AGGREGATE EXCESS REPORT**.

a. You or the **Administrator** will send us an Aggregate Excess Report (in a form satisfactory to us), within twenty (20) days after the end of each calendar month during the **Policy Period**, containing the following data:

i. The number of **Employees** in each **Covered Unit** who are covered by the **Plan** as of the first day of the reporting month; and

ii. The total amount of **Losses** for all covered **Persons** during the reporting month.

b. Reported **Losses** must be within the **Loss Limit Per Person** shown in Schedule Item 7(b).

c. This report will identify and segregate **Losses** by each **Covered Unit**.

11. **PROOF OF LOSS**.

a. **SPECIFIC EXCESS CLAIMS**. We will reimburse you for a **Loss** covered by the **Policy** after we receive satisfactory **Proof of Loss**, as solely defined by us, that you or the **Administrator** has **Paid** the **Loss**. Satisfactory **Proof of Loss** of a Specific Excess claim includes, but is not limited to:

i. our completed loss advice form;

ii. proof of eligibility under the **Plan**;

iii. claim payment report with the following data: provider of services, **Incurred** from and to dates, service/procedure codes, billed amounts, **Paid** amounts, **Paid** dates, and check numbers;

iv. itemized medical bills (as applicable);

v. invoices from managed care and other cost containment vendors;

vi. comprehensive case management reports with updates;

vii. attending physician statements and medical narratives;

viii. date the accident occurred or date the sickness was diagnosed; and

ix. date that medical care was first received.

b. **AGGREGATE EXCESS CLAIM**. After the end of the **Policy Period**, we will reimburse you for **Losses** covered by this **Policy** after we receive satisfactory **Proof of Loss** that you or the **Administrator** has **Paid** the **Loss**. You or the **Administrator** must provide us with **Proof of Loss** within ninety (90) days after the end of the period shown in Schedule Item 7(a)(2) in order for us to consider reimbursing an Aggregate Excess claim. Satisfactory **Proof of Loss** of an Aggregate Excess claim includes, but is not limited to:

i. our completed loss advice form;

ii. computer reports of total **Paid** claims (month-by-month) during the **Policy Period** showing claimant, **Incurred** date, service/procedure code, billed amount, **Paid** date, provider and amount **Paid**;

iii. computer reports showing total **Employee** census information (month-by-month) during the **Policy Period**; and

iv. documentation showing any voided payments, refunds, or other adjustments.

c. **ADDITIONAL DOCUMENTATION**. If we ask for **Loss** documentation that is not described in subsections a. or b. above, you agree to provide or require your **Administrator** to provide such documentation to us. It is your responsibility and financial obligation to provide us with satisfactory **Proof of Loss**.

~~sole discretion.~~12. **CLAIMS APPEAL PROCESS**. You may appeal any claim determination made by us under this **Policy** by submitting a written appeal within ninety (90) days from the date of our initial claim determination. Your written appeal must clearly state the basis of your disagreement with our claim determination and include all relevant documentation in support of your appeal that has not been previously provided to us.

Any appeal of a claim determination made by us on the grounds that the **Treatment** provided was either (i) not **Medically Necessary**; (ii) Cosmetic, Custodial in Nature, or Unproven; or (iii) **Experimental and/or Investigational**, must include a report from an **Independent Medical Review**. The **Independent Medical**

Review report will be obtained at your expense. The utilized independent review organization must be mutually acceptable to you and us.

SECTION EIGHT: RENEWAL AND CANCELLATION

1. **RENEWAL**. In order for us to offer you a renewal for succeeding **Policy Periods**, you must provide us the following information at least ~~two~~three (3) months prior to the end of the **Policy Period**:

   a. a list ~~naming each~~of every **Employee** and the eligible dependents of each **Employee**, identified by the applicable **Covered Unit**, showing each **Person's** age ~~and~~, gender, and rating classification;

   b. the total number of **Employees** working within each U.S. Postal Service Zip Code area for each **Covered Unit**;

   c. the applicable PPO network for each **Employee**;

   d. a report summarizing claims, segregated by the applicable **Covered Unit**, which exceed, or may exceed, fifty percent (50~~%~~%) of the Retention for each **Person** shown in Schedule Item 6(b), or any **Persons** who have been diagnosed with a condition ~~that has been named~~listed in ~~an~~the Major Diagnosis **Endorsement** attached to this **Policy**~~, identified~~. The report will also identify any pending, denied, or claims placed on hold by ~~the applicable **Covered Unit**~~you or your **Administrator** for the prior twelve (12) months;

   ~~d~~e. a report summarizing aggregate month-by-month paid claims for all covered **Persons** along with monthly census and any specific claims excess of the Loss Limit Per Person;

   f. any **Plan ~~Changes~~Change(s)** that are being considered by you; and

   ~~e~~g. any other information we may request.

2. **NONRENEWAL**. If we elect not to renew this **Policy** ~~for any succeeding **Policy Periods**~~, we will give you written notice by registered mail at least thirty (30) days, or longer if required by law, prior to the end of the **Policy Period** stating our reason for the nonrenewal.

3. ~~**CANCELLATION**.~~ **CANCELLATION**.

   a. You may cancel ~~and terminate~~ this **Policy** at any time by giving us thirty (30) days advance written notice stating the cancellation date. ~~Unless you get written consent from us, termination of the contract between you and the **Administrator** will~~

   b. We may cancel this **Policy** as of ~~the~~:

      i. The date ~~that~~ your contract ~~with the~~between you and the **Administrator** is cancelled, unless we give written consent and approve the replacement **Administrator** ~~terminates. We will provide you with~~, if any;

      ii. The date your **Plan** is terminated;

iii. The date in which premium was due but has not been paid by you within the Grace Period (pursuant to Section Two: Premium, Items 3 and 4);

iv. The first day of the month in which the number of covered **Employee**s falls below one hundred (100) lives; or

v. The sixty-first (61st) day following issuance of notice by us to you for your failure or the failure of your **Administrator** to satisfy your obligations under this **Policy**, and such obligation had not been subsequently remedied.

c. Notice of cancellation by either party to the other will be given by registered mail, or as may be required by applicable law, stating the cancellation date. ~~If not cancelled, this **Policy** will remain in force until the end of the~~

4. **TERMINATION OF COVERAGE**. In the event this **Policy** ~~**Period**~~ is cancelled by you or by us pursuant to Item 3 above, and prior to the expiration of the **Policy Period**, as defined in Schedule Item 4, the following **Policy** terms will be revised to reflect the notified **Policy** cancellation date:

a. Schedule Item 4 – **Policy Period** end date;

b. Schedule Item 6(a)(1) – Specific Excess, Liability Basis, Claims Incurred end date;

c. Schedule Item 6(a)(2) – Specific Excess, Liability Basis, Claims Paid end date;

d. Schedule Item 7(a)(1) – Aggregate Excess, Liability Basis, Claims Incurred end date, if applicable; and

e. Schedule Item 7(a)(2) – Aggregate Excess, Liability Basis, Claims Paid end date, if applicable.

SECTION ~~EIGHT~~NINE: GENERAL PROVISIONS

1. **BANKRUPTCY**. Your bankruptcy will not relieve us from the payment of any claim covered by this **Policy**. Nothing in the **Policy** will increase our liability under the **Policy** beyond that which it would otherwise be if you had not become insolvent or bankrupt.

2. **INSPECTION OF RECORDS**. We or our representatives have the right (at no cost to us) to inspect any books, records or other documentation applicable to the **Plan** which are kept by you and/or the **Administrator**. The inspection may be made by us or our representatives at any time during the normal business hours of the organization where the inspection takes place.

3. **LEGAL ACTION**. No action at law or in equity will be brought against us to recover on this **Policy** prior to the expiration of sixty (60) days after written ~~proof~~**Proof of Loss** has been furnished in accordance with the requirements of this **Policy**. No such action will be brought more than two (2) years after the time written ~~proof~~**Proof of Loss** is required to be furnished.

4. **SUBROGATION AND RIGHT OF RECOVERY**. You agree to prosecute any and all valid claims against any third party that may arise from any claim for which **Benefits** were **Paid** under the **Plan**. You or the **Administrator** will notify us of any subrogation claims and will account to us for any **Losses** recovered. If you or the **Administrator** fails to pursue any action against any third party and you have received, or are entitled to receive, reimbursements from us for **Benefits Paid** under the **Plan**, we will be subrogated to your rights and the rights of any **Person** under the **Plan**. We have the ~~Right~~right of ~~Recovery~~recovery to any amounts you or any **Person** receiving **Benefits** under the **Plan** recover from any third party who is found liable for these amounts. You will do everything necessary to protect these rights and to help us enforce them. The recovered **Loss** remaining after deducting the expenses of our recovery will first be used to reduce our **Loss**; then we will pay the balance, if any, to you.

5. **CLERICAL ERROR**. This **Policy** will not be invalidated or terminated by ~~Clerical Error~~clerical error or mutual mistake. Clerical ~~Error~~error or mutual mistake will not continue this **Policy** if it has been terminated, and it will not expand our obligations under this **Policy**. Upon discovery of such ~~Clerical Error~~clerical error, the **Policy** will be restored and amended to reflect the terms and conditions that were agreed to at the time of its execution.

6. **OTHER INSURANCE**. If any other insurance exists protecting you against **Loss** covered by this **Policy**, this **Policy** will apply in excess of the other insurance.

7. **PARTIES**. We are the Insurer under this **Policy** and you are the Insured. ~~Your~~ **Employees** and their dependents are not parties to this **Policy**. We do not insure or pay **Benefits** to your **Employees** or their dependents under the **Plan**. We are limited under the **Policy** to reimbursing you for **Losses** under this **Policy** that are **Incurred** and **Paid** by you as self-insurer of the **Plan**.

8. **REPRESENTATIONS**. We issued and may renew this **Policy** relying upon the information furnished us as to the number of your **Employees** and the claims experience under the **Plan**. If the initial or renewal underwriting information is incorrect or incomplete, we have the right to amend the **Schedule** to reflect what we would have shown in the **Schedule** using the accurate and complete information. This amendment will be effective at the beginning of the **Policy Period** in which we learn of the incorrect or incomplete information.

~~9~~9. **REFUND OF OVERPAYMENTS**. If we, you or the **Administrator** determine that we have overpaid under this **Policy** due to a claim credit which may be the result of a coordination of benefits change, a subrogation recovery, an audit or billing/payment error or other circumstance, then you will promptly refund such overpayment to us within sixty (60) days of discovery of the overpayment. We reserve the right to recover such overpayments from future claim payments due under this **Policy** if a refund payment is not received within sixty (60) days. If no future claim payments are due and the refund of an overpayment is not made by you, then we may take legal action to collect such overpayment. You agree to indemnify us for any cost of collection, including but not limited to, attorney's fees and court cost.

10. **SELF-INSURANCE**. You are now and will remain until the end of the **Policy Period** self-insured for the **Benefits** provided by the **Plan**. It is your responsibility to make all filings required by federal and state authorities regulating self-insured plans.

~~10~~11. **TRANSFER**. Your rights or duties under this **Policy** may not be transferred or assigned to anyone else without our written consent.

~~11~~12. **CHANGES**. Notice to or knowledge possessed by any agent, broker, or other person shall not effect a change or waiver of any part of this **Policy**, nor prevent us from asserting any rights under this **Policy**. No part of this **Policy** can be changed or waived, except by written **Endorsement** issued by us.

~~12~~

13. **HEADINGS**. The descriptions in the headings and sub-headings of this **Policy** are solely for convenience, and form no part of the terms and conditions of coverage.

~~13~~14. **ENTIRE AGREEMENT**. The parties agree that this **Policy**, including the **Schedule**, the ~~Declaration Letter(s),~~Disclosure Statement, the Binder, the **Plan**, Exhibits, and any **Endorsements**, constitutes the entire agreement between you and us relating to this **Policy**.

We executed this **Policy** by printing the facsimile signatures of our President and ~~Assistant~~ Secretary on the attached signature page and by the actual signature of ~~our~~the authorized North American Specialty Insurance Company representative on the **Schedule** ~~pages~~.

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

QUARTERLY PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

~~**SECTION TWO: PREMIUM.**~~ I. Schedule Item 6. Specific Excess, subsection g. Premium is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

g. Premium:

Rating Classification	**Quarterly Rate**

II. Schedule Item 7. Aggregate Excess, subsection h. Monthly Premium Rate is deleted and replaced with the following:

7. **AGGREGATE EXCESS**:

h. Quarterly Premium Rate:

II. Section Two: Premium is deleted in its entirety and replaced ~~by~~with the following:

SECTION TWO: PREMIUM

~~1.~~ 1. **CALCULATION**.~~–~~ The ~~**Premium**~~premium for each three months under the **Policy Period** ("Policy Quarter") that is due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the ~~1st~~first day of each ~~quarter~~Policy Quarter.

~~2.~~ 2. **DUE DATE**~~.~~ **AND QUARTERLY REPORT**. Premium ~~for each quarter~~ is due ~~to us~~ on the first day of ~~the three months~~each Policy Quarter during the **Policy Period**. Each ~~**Premium**~~premium payment must be accompanied by a report showing the total number of **Employees** as of the first day of each ~~quarter who are part of each~~Policy Quarter covered under the **Policy**. If your **Policy** has more than one Rating Classification ~~shown~~, as stated in Schedule Items 6(g~~) and 7(h). –~~), then your report should also reflect a breakout of **Employee** numbers per Rating Classification.

~~3.~~ 3. **GRACE PERIOD**. ~~Coverage under this **Policy** shall continue in full force and effect during the Grace Period.~~ A Grace Period of thirty-one (31) days following the ~~**Premium**~~premium due date will be granted for the payment of each quarterly ~~**Premium**~~premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period.

~~4.~~ 4. **NON-PAYMENT**. ~~–~~Failure to pay ~~any quarterly **Premium**~~in full the Policy Quarter premium within ~~31 days after the **Premium** due date~~the Grace Period will cancel the **Policy** as of the ~~**Premium**~~premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full Policy Quarter premium is not paid prior to the expiration of the Grace Period.

5. **REINSTATEMENT**. If any Policy Quarter premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate the **Policy** on the terms and conditions that we select at that time.

6. **ADJUSTMENTS.** If you pay any Policy Quarter premium in excess of the amounts due, you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next quarterly premium payment due. A request for refund or a claim offset for a future quarterly premium payment must be given to us in writing, stating the basis and calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the Policy Quarter premium payment amount was adjusted. No Policy Quarter premium adjustments will be allowed after ninety (90) days following the conclusion of the **Policy Period**.

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted President

Facsimile signature to be inserted Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ANNUAL PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

It is agreed that the **Policy** is hereby amended as follows:

~~**SECTION TWO: PREMIUM,**~~ I. Section Two: Premium is hereby deleted in its entirety and replaced by the following:

SECTION TWO: **PREMIUM**

~~1.~~ 1. **DEPOSIT PREMIUM**. A deposit ~~**Premium**~~premium of $_____ is due on the first day of the **Policy Period**.

~~2.~~ 2. **CENSUS REPORT**. Within twenty (20) days after the end of the **Policy Period**, you must send us a census report showing the number of **Employees** within each rating classification shown in Schedule Item 6(g) who were covered by the **Plan** on the first day of each month in the **Policy Period**.

~~3.~~ 3. **FINAL PREMIUM**. The final ~~**Premium**~~premium due ~~us~~ for the **Policy Period** shall be determined by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan**.

~~4.~~ 4. **ADJUSTMENT PREMIUM**. At the end of the **Policy Period**:

~~a)~~ a. if the final ~~**Premium**~~premium is more than the deposit ~~**Premium**~~, premium, you will send us your payment of the difference along with the Census Report; or

~~b)~~ b. if the final ~~**Premium**~~premium is less than the deposit ~~**Premium**~~premium, we will return the difference to you promptly after we receive the Census Report.

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

NON-MEDICAL BENEFITS COVERED
SPECIFIC EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As ~~respects **Loss** as a result of accidents taking place and sicknesses diagnosed on and after~~of the effective date of this **Endorsement**, Schedule Item~~(s)~~ 6(f) ~~and 7(g) are amended to read as follows~~is deleted and replaced with the following:

6~~(~~. **SPECIFIC EXCESS**:

f~~).~~. Non-medical Benefits covered:

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted *Facsimile signature to be inserted*

~~Authorized Representative~~ President Secretary

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

ADD COVERED UNIT(S)
SPECIFIC EXCESS ENDORSEMENT

As respects accidents taking place and sicknesses diagnosed on or after**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(e) is deleted and replaced with the following:

6. **SPECIFIC EXCESS**:

e. Covered Unit(s):

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

Countersigned.

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

Authorized Representative

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

MAJOR ~~DIAGNOSES~~DIAGNOSIS ENDORSEMENT

~~SECTION THREE: SPECIFIC EXCESS~~ Paragraph 4. ~~Notice~~THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that this Policy is hereby amended as follows:

Pursuant to ~~include the following language:~~

~~You~~Section Seven: Claims, Item 7, you or the **Administrator** will give us written notice if any covered **Person** has been diagnosed with any of the following ICD-9 Codes or Diagnoses identified in Item I below or otherwise identified in Item II below:

I. **Diagnoses**	**ICD-9 Codes**
Accidental Injury classified with an "E" code.	Any "E" code
~~AIDS/HIV+; AIDs/HIV related complication~~AIDS	~~007-011, 031, 040-49, 070, 078, 079, 112-18, 130, 136~~ 042
Alpha 1 (Antitrypsin Deficiency)	277.6
Amyloidosis	277.3
Anterior Horn Cell Disease	335.2
Blood Disorder (Hemophilia, aplastic anemia sickle cell, primary thrombocytopenia, etc.)	~~271-277, 279-282, 284,~~ 286-~~288~~287.9
Burn - Severe	941-949
Cancer, Leukemia, Lymphoma, etc.	140-~~208, 230-~~239.9
Cardiomyopathy	425
Cerebral Vascular Disease/Stroke	430-438
Chronic Inflammatory Demylinating Polyneuropathy (CIDP)	356
Congenital ~~Heart Defect or Pulmonary Defect~~ Anomalies/Premature Infants	~~745-748~~740-779.9
~~Growth Hormone Deficiency~~ Cystic Fibrosis	~~253~~277
~~Dwarfism~~ Gaucher's Disease	~~259~~272.7
Heart/Lung Disease	416-429
Hepatitis	070
High Risk Pregnancy	640-648, 651, V23.4
~~Infections (cellulitis, osteomyelitis)~~ Liver Disease	~~682-83, 730~~570-573
Multiple Sclerosis	340
~~Digestive Disorder or Renal~~Nervous System Disorder~~ (Crohn's, cirrhosis, renal failure, pancreatitis, etc.)~~	~~555, 570-573, 577, 579, 581-585~~320-389
Pancreatitis	577
Renal Disease	584-587
Respiratory Problem	416 480-482, 496, 513-516, 519
~~Major~~ Traumatic Injury - Major (spinal cord,	800-809, 828-829, 850-54, 860-871, 873-

head, trauma, etc.)	875, 885-887, 895-897, 900-904, 925-929, 952-953
~~Nervous System Disorder~~	~~323, 335-345, 348-349, 357, 359~~
~~Premature Infant/Newborn complication or congenital anomalies~~	~~740-742, 759-780~~
~~Respiratory Problem~~	~~416-480-482, 496, 513-516, 519~~
~~Accidental Injury classified with an "E" code.~~	~~Any "E" code~~

II. ALSO IDENTIFY ANY OF THE FOLLOWING:

- Potential transplants, except cornea (Including transplant rejection or complications).
- Any **Person** with three (3) or more ~~inpatient~~ admissions in ~~less than~~a six ~~months~~(6) month period.
- Any **Person** with one (1) hospitalization of seven (7) days or more.

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted

President

Facsimile signature to be inserted

Secretary

~~Authorized Representative~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

PARTICIPANT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ ~~it~~IT CAREFULLY.

IT IS ~~HEREBY~~ AGREED that ~~this Excess Medical Indemnity~~ the **Policy** is hereby amended ~~to the extent necessary to eliminate any inconsistencies between it and the following~~as follows:

I. Section One: Definitions ~~5~~, Item 6. Employee is deleted in its entirety and replaced by the following:

~~5~~6. **Participant** means any individual who is employed by or otherwise participates in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired P**articipants** or the dependents of retired **Participants** unless otherwise agreed to by us.

II. Throughout this **Policy**, the term ~~"~~"**Employee**~~"~~" is hereby deleted and replaced with the term ~~"~~"**Participant**~~."~~"."

All other terms and conditions of this ~~policy~~**Policy** shall remain unchanged.

This ~~endorsement~~**Endorsement** forms a part of the ~~policy~~**Policy** to which attached, effective on the inception date of the ~~policy~~**Policy** unless otherwise stated herein.

(The information below is required only when this ~~endorsement~~**Endorsement** is issued subsequent to the preparation of the ~~policy~~**Policy**.)

Endorsement Effective		**Policy No.**	
Named Insured			

~~Countersigned.~~

NORTH AMERICAN SPECIALTY INSURANCE COMPANY

Facsimile signature to be inserted — President

Facsimile signature to be inserted — Secretary

~~Authorized Representative~~